S. Hrg. 98-1211

VETERANS' ADMINISTRATION HEALTH CARE AMENDMENTS OF 1984

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

ON

S. 2210, S. 2269, Amendment No. 2850 to S. 2269, S. 2278, S. 2514 and Related Bills

APRIL 11, 1984

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CONTENTS

Page

Opening statement of Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs 1

Bill S. 2210, as referred to the Committee on Veterans' Affairs:

Text of 32
Agency report of the Veterans' Administration (No. 75, May 7, 1984) 33

Bill S. 2269, as referred to the Committee on Veterans' Affairs:

Text of 37
Introductory statement of the author, Hon. Alan Cranston, excerpts from the Congressional Record, vol. 130, No. 12, pp. S1084-S1089—Senate, February 7, 1984 46
Amendment No. 2850, excerpts from the Congressional Record, vol. 130, No. 37, pp. S3248-S3252—Senate, March 27, 1984 50

Bill S. 2278, as referred to the Committee on Veterans' Affairs:

Text of 54
Introductory statement of the author, Hon. Rudy Boschwitz, excerpts from the Congressional Record, vol. 130, No. 13, pp. S1185-S1186—Senate, February 8, 1984 56
Agency report of the Veterans' Administration (No. 79, May 21, 1984) 57

Bill S. 2514, as referred to the Committee on Veterans' Affairs:

Text of 59
Introductory statement of the author, Hon. Alan K. Simpson, excerpts from the Congressional Record, vol. 130, No. 40, pp. S3533-S3536—Senate, March 30, 1984 70
Agency report of the Veterans' Administration (No. 85, July 16, 1984) 72

Testimony of:

A panel consisting of: Donald L. Custis, M.D., Chief Medical Director, Veterans' Administration, accompanied by D. Earl Brown, Jr., M.D., Associate Deputy Chief Medical Director; A. Audley Hendricks, Assistant General Counsel; and Marjorie R. Quandt, Assistant Chief Medical Director for Administration 90
A panel consisting of: Ewald W. Busse, M.D., dean emeritus, Duke University Medical Center, Durham, NC, and Chairman of the Geriatrics and Gerontology Advisory Committee to the Veterans' Administration; and Terrie Wetle, Ph.D., assistant professor, Division of Health Policy Research and Education, Harvard University Medical School, Cambridge, MA 233
A panel consisting of: Leonard Saxe, Ph.D., psychologist, Boston University, accompanied by Denise Dougherty, Office of Technology Assessment; Sandra K. Hill, R.N., C.A.C., M.B.A., director, Suburban Hospitals' Alcoholism Treatment Services, Bethesda, MD, and president, board of trustees, Baltimore Alcoholism Treatment Center, Baltimore, MD; and Leo Ruffing, member of the board of directors, Association of Halfway House Alcoholism Programs of North America, Inc., St. Paul, MN, accompanied by Donald Anderson, director, Serenity House Alcoholism Recovery Program, Newport News, VA 251
John R. Smith, M.A., Clinical Program Director appointee, Center for Trauma Recovery, Brecksville Division, VA Medical Center, Cleveland, OH 288
A panel consisting of: Martin H. Cohen, M.D., Chief, Oncology Section, Veterans' Administration Medical Center, Washington, DC; and Sharron Dreyer, B.S.N., assistant administrator, Patient Care Services, Hospice of Northern Virginia, Inc., Arlington, VA 315

Page

Testimony of—Continued

A panel of representatives of veterans' organizations, consisting of: John F. Sommer, Jr., deputy director, National Veterans Affairs and Rehabilitation Commission, The American Legion, accompanied by Paul S. Egan, deputy director, National Legislative Commission; Philip R. Mayo, special assistant, National Legislative Service, Veterans of Foreign Wars of the United States; David W. Gorman, associate deputy national legislative director, Disabled American Veterans; and R. Jack Powell, executive director, Paralyzed Veterans of America 369

Written statement of:

Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs 3
Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs 13
Hon. George J. Mitchell, a U.S. Senator from the State of Maine 18
Hon. Rudy Boschwitz, a U.S. Senator from the State of Minnesota 30
Donald L. Custis, M.D., Chief Medical Director, Veterans' Administration. 93
Ewald W. Busse, M.D., dean emeritus, Duke University Medical Center, Durham, NC, and chairman of the Geriatrics and Gerontology Advisory Committee to the Veterans' Administration 235
Terrie Wetle, Ph.D., assistant professor, Division of Health Policy Research and Education, Harvard University Medical School, Cambridge, MA 239
Leonard Saxe, Ph.D., psychologist, Boston University, Boston, MA 254
Sandra K. Hill, R.N., C.A.C., M.B.A., director, Suburban Hospital's Alcoholism Treatment Services, Bethesda, MD, and president, board of trustees, Baltimore Alcoholism Treatment Center, Baltimore, MD 268
Leo Ruffing, member of the board of directors, Association of Halfway House Alcoholism Programs of North America, Inc., St. Paul, MN 274
John R. Smith, M.A., clinical program director appointee, Center for Trauma Recovery, Brecksville Division, VA Medical Center, Cleveland, OH 291
Martin H. Cohen, M.D., Chief, oncology section, Veterans' Administration Medical Center, Washington, DC 317
Sharron Dreyer, B.S.N., assistant administrator, Patient Care Services, Hospice of Northern Virginia, Inc., Arlington, VA 329
John F. Sommer, Jr., deputy director, National Veterans Affairs and Rehabilitation Commission, The American Legion 371
Philip R. Mayo, special assistant, National Legislative Service, Veterans of Foreign Wars of the United States 393
David W. Gorman, associate deputy national legislative director, Disabled American Veterans 402
R. Jack Powell, executive director, Paralyzed Veterans of America 413
Gwenyth R. Vaughn, Ph.D., Chief of Audiology and Speech Pathology Service, Veterans' Administration Medical Center, Birmingham, AL 442
Joe Collins, executive director, California Association of Alcoholic Recovery Homes, Inc., Los Angeles, CA 446
Jack J. Dack, legislative chairman, National Association of State Veterans Homes 461
Joan M. Maiman, Vietnam civilian volunteer, Chicago, IL 472
Maureen E. Nerli, Vietnam civilian volunteer, Burlingame, CA 474

Questions and answers:

Response to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, from:

Veterans' Administration 131
Ewald W. Busse, M.D., dean emeritus, Duke University, Durham, NC, and chairman of the Geriatrics and Gerontology Advisory Committee to the Veterans' Administration 250
Leonard Saxe, Ph.D., assistant professor, Department of Psychology, Boston University, Boston, MA 281
Sandra K. Hill, R.N., C.A.C., M.B.A., director, Suburban Hospital's Alcoholism Treatment Services, Bethesda, MD, and president, board of trustees, Baltimore Alcoholism Treatment Center, Baltimore, MD 283
Leo Ruffing, member of the board of directors, Association of Halfway House Alcoholism Programs of North America, Inc., St. Paul, MN 287

Page

- Questions and answers—Continued
  - Response to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, from—Continued
    - John R. Smith, M.A., Clinical Program Director appointee, Center for Trauma Recovery, Brecksville Division, VA Medical Center, Cleveland, OH ... 308
    - Martin H. Cohen, M.D., Chief, Oncology Section, Veterans' Administration Medical Center, Washington, DC ... 341
    - Sharron Dreyer, B.S.N., assistant administrator, Patient Care Services, Hospice of Northern Virginia, Inc., Arlington, VA ... 368
    - The American Legion ... 424
    - Veterans of Foreign Wars of the United States ... 428
    - Disabled American Veterans ... 431
    - Paralyzed Veterans of America ... 439
  - Response to written questions submitted by Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, from:
    - Veterans' Administration ... 184
    - Ewald W. Busse, M.D., dean emeritus, Duke University, Durham, NC, and chairman of the Geriatrics and Gerontology Advisory Committee to the Veterans' Administration ... 250
    - Martin H. Cohen, M.D., Chief, Oncology Section, Veterans' Administration Medical Center, Washington, DC ... 365
    - Sharron Dreyer, B.S.N., assistant administrator, Patient Care Services, Hospice of Northern Virginia, Inc., Arlington, VA ... 369
    - The American Legion ... 426
    - Veterans of Foreign Wars of the United States ... 430
    - Disabled American Veterans ... 435
  - Response of the Veterans' Administration to written questions submitted by:
    - Hon. Strom Thurmond, a U.S. Senator from the State of South Carolina ... 217
    - Hon. Rudy Boschwitz, a U.S. Senator from the State of Minnesota ... 218
- Letters to:
  - Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, from:
    - Hon. William S. Cohen, a U.S. Senator from the State of Maine, dated April 11, 1984 ... 477
    - Ken Schonlau, president, Association of Halfway House Alcoholism Programs of North America, Inc., dated April 3, 1984 ... 479
    - Arthur L. Arnold, M.D., Chief, Psychiatry Service, Veterans' Administration Medical Center, Phoenix, AZ, dated May 3, 1984 ... 480
  - Dr. Donald L. Custis, Chief Medical Director, Veterans' Administration, from Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, dated March 13, 1984 ... 482
  - Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, from:
    - Donald L. Custis, M.D., Chief Medical Director, Veterans' Administration, Washington, DC, dated April 10, 1984 ... 483
    - Kenneth R. Lemon, C.A.C., administration director, Sunrise, Inc., Larned, KS, dated April 17, 1984 ... 490
  - Hon. George J. Mitchell, a U.S. Senator from the State of Maine, from Harry N. Walters, Administrator, Veterans' Administration, Washington, DC, dated May 2, 1984 ... 502

APPENDIXES

Appendix A.—Bill S. 2514, as reported by the Committee on Veterans' Affairs, with an amendment and an amendment to the title, May 25, 1984 ... 509
Appendix B.—Excerpts from Senate Report No. 98-487 to S. 2514, May 25, 1984 ... 548
Appendix C.—Excerpts from the Congressional Record on S. 2514, vol. 130, No. 105, pp. S10100-S10135—Senate, August 8, 1984 ... 649
Appendix D.—Excerpts from the Congressional Record on a message from the House of Representatives on H.R. 5618, vol. 130, No. 129—Part II, pp. S12892-S12906—Senate, October 3, 1984 ... 673
Appendix E.—Public Law 98-528 (98th Cong., H.R. 5618, Oct. 19, 1984) ... 686

VETERANS' ADMINISTRATION HEALTH CARE AMENDMENTS OF 1984

WEDNESDAY, APRIL 11, 1984

U.S. Senate,
Committee on Veterans' Affairs,
Washington, DC.

The committee met, pursuant to notice, at 10:10 a.m., in room SR-418, Russell Office Building, Hon. Alan K. Simpson (chairman of the committee) presiding.

Present: Chairman Alan K. Simpson, Senators Alan Cranston, Strom Thurmond, and George J. Mitchell.

OPENING STATEMENT OF HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Chairman Simpson. Good morning and welcome to the Committee on Veterans' Affairs hearing. We are going to consider several legislative proposals which would address certain health-care programs administered by the VA, testimony on several bills I have introduced, S. 2514 and S. 2210, S. 2269, introduced by my fine colleague from California, and an amendment to S. 2269 proposed by Senator Cranston. The names of the various bills will be included in the record.

We will hear from the VA, members of the private sector, health-care specialists, representatives from the veterans groups and see what we have for us which would improve the VA's efforts to deliver quality health care to our Nation's veterans. During my tenure as chairman, we have pondered and we have probed a number of important issues, which I believe are critical to the ability of the VA to provide high quality health-care services to the Nation's veterans. Of course, we must continue to think of the staggering size of the Federal deficit that we are dealing with on the floor of the Senate this week, its implications for all programs, not just VA; the future of fulfilling what has been an unwavering commitment to take care of the Nation's veterans who gave a special effort and who are now disabled; health care to elderly veterans, the need for which is going to continue to increase in intensity and scope, including alternatives to institutionalization; the question of eligibility and how to cope with expanding demand within the context of a very finite amount of resources; and the question of the use of limited resources to renovate, replace, or construct VA centers and nursing homes.

Of equal magnitude and importance is the question of quality of care, an abstract concept which often really defies our attempts to measure and quantify. I firmly believe the issue of quality of care is an important factor in every policy decision that the Congress must make with respect to the authorization and appropriation of health-care dollars for use by the VA and every administrative and management decision that is made by the VA with respect to the allocation of those resources to improve existing services and to establish new programs.

It is a tough task, because the VA must balance the need to serve large numbers of veterans with the management task of allocating sufficient numbers and kinds of staff and resources to accomplish its missions. We in the Congress would like to provide the VA with sufficient flexibility to make these very hard management decisions and to indeed practice your professional course, which is the practice of medicine and to take care of our Nation's veterans as the health-care professionals have been trained and are qualified well to do. And I have no desire to dabble in restricting or commenting upon the practice of medicine. That is not my intent, but certainly there are some guidelines that have to be discussed with regard to the VA's capabilities within the context of oversight by this committee. The responsibility of Congress is to be accountable to the citizens of the country, including the veterans, for the scope of medical care programs provided in our own VA facilities.

At the same time it is the appropriate role of the Congress and my commitment as chairman to oversee more than an $8 billion medical care budget. In that regard, we continue to seek a dialog on the services it provides, what services it feels it should continue to provide, and the eligibility, all of those things, implications of those used for the future of the system. Certainly, we will not always agree on those things, but I have enjoyed working with the VA in the spirit of cooperation as we pursue that.

So we seek your testimony today from these various resources that are here to testify in order that we might benefit from your experience and knowledge in these areas.

We have quite a number of issues that will be discussed and I request that you summarize your statements in no more than 5 minutes and then highlight one or two issues that you may wish to particularly emphasize. And we will allow 10 minutes per member for questions on the first round and an additional 10-minute period for questions thereafter.

Of course the entire statements of the witnesses will be included in the record in the appropriate place.

[The prepared statement of Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, follows:]

PREPARED STATEMENT OF HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

GOOD MORNING AND WELCOME TO THE COMMITTEE ON VETERANS' AFFAIRS' HEARING ON ISSUES PERTAINING TO VETERANS HEALTH CARE. THE PURPOSE OF THE HEARING TODAY IS TO CONSIDER SEVERAL LEGISLATIVE PROPOSALS WHICH WOULD ADDRESS CERTAIN HEALTH CARE PROGRAMS ADMINISTERED BY THE VA.

WE WILL RECEIVE TESTIMONY ON THE BILLS I HAVE INTRODUCED, S. 2514, THE PROPOSED "VETERANS ADMINISTRATION HEALTH CARE AMENDMENTS OF 1984" AND S. 2210, A BILL TO REVISE AND CLARIFY THE ELIGIBILITY OF CERTAIN DISABLED VETERANS FOR AUTOMOBILE ADAPTIVE EQUIPMENT; S. 2269, THE PROPOSED "VETERANS' ADMINISTRATION HEALTH-CARE IMPROVEMENTS ACT OF 1984", INTRODUCED BY MY COLLEAGUE FROM CALIFORNIA, SENATOR ALAN CRANSTON; SENATE AMENDMENT NO. 2850 TO S. 2269, ALSO PROPOSED BY SENATOR CRANSTON; AND S. 2278, THE PROPOSED "CARE FOR CHEMICALLY DEPENDENT VETERANS ACT", INTRODUCED BY SENATOR BOSCHWITZ.

WE WILL HEAR TODAY THE VIEWS OF REPRESENTATIVES OF THE VETERANS' ADMINISTRATION, HEALTH CARE SPECIALISTS FROM THE PRIVATE SECTOR; AND REPRESENTATIVES OF THE AMERICAN LEGION, THE VETERANS OF FOREIGN WARS, THE DISABLED AMERICAN VETERANS, AND THE PARALYZED VETERANS OF AMERICA ON THOSE LEGISLATIVE PROPOSALS BEFORE US WHICH WOULD IMPROVE THE VA'S EFFORTS TO DELIVER QUALITY HEALTH CARE TO OUR NATION'S VETERANS.

THROUGHOUT MY TENURE AS CHAIRMAN OF THE VETERANS' AFFAIRS COMMITTEE, I HAVE PONDERED AND PROBED A NUMBER OF IMPORTANT ISSUES, WHICH I BELIEVE ARE CRITICAL TO THE ABILITY OF THE VA TO PROVIDE HIGH QUALITY HEALTH CARE SERVICES TO OUR NATION'S VETERANS. THESE ISSUES INCLUDE THE STAGGERING SIZE OF THE DEFICIT AND ITS IMPLICATIONS FOR VA PROGRAMS NOW AND IN THE FUTURE; THE QUESTION OF FULFILLING OUR UNWAVERING COMMITMENT TO SERVE THOSE, WHO IN DEFENSE OF OUR COUNTRY, ARE NOW DISABLED; THE QUESTION OF PROVIDING HEALTH CARE TO OUR ELDERLY VETERANS, INCLUDING ALTERNATIVES TO INSTITUTIONALIZATION, WITHIN THE CONTEXT OF A FINITE AMOUNT OF RESOURCES; THE QUESTION OF ELIGIBILITY AND HOW TO COPE WITH EXPANDING DEMAND; AND THE QUESTION OF THE USE OF THESE LIMITED RESOURCES TO RENOVATE, REPLACE OR CONSTRUCT VA MEDICAL CENTERS AND NURSING HOMES.

OF EQUAL MAGNITUDE AND IMPORTANCE IS THE QUESTION OF QUALITY OF CARE, AN ABSTRACT CONCEPT WHICH OFTEN DEFIES ATTEMPTS AT MEASUREMENT AND QUANTIFICATION. I FIRMLY BELIEVE THE ISSUE OF QUALITY OF CARE IS AN IMPORTANT FACTOR IN EVERY POLICY DECISION THAT THE CONGRESS MUST MAKE WITH RESPECT TO THE AUTHORIZATION AND APPROPRIATION OF HEALTH CARE DOLLARS FOR USE BY THE VA AND EVERY ADMINISTRATIVE AND MANAGEMENT DECISION THAT IS MADE BY THE VETERANS' ADMINISTRATION WITH RESPECT TO THE ALLOCATION OF THOSE RESOURCES TO IMPROVE EXISTING SERVICES AND TO ESTABLISH NEW PROGRAMS.

THE VA HAS A DIFFICULT TASK BECAUSE IT MUST BALANCE THE NEED TO SERVE LARGE NUMBERS OF VETERANS WITH THE MANAGEMENT TASK OF ALLOCATING SUFFICIENT NUMBERS AND KINDS OF STAFF AND RESOURCES TO ACCOMPLISH ITS MISSIONS. WE IN THE CONGRESS WOULD LIKE TO PROVIDE THE VA WITH SUFFICIENT FLEXIBILITY TO MAKE THESE VERY HARD MANAGEMENT DECISIONS AND TO PRACTICE MEDICINE AND CARE FOR OUR NATION'S VETERANS WHICH THEY AS HEALTH CARE PROFESSIONALS HAVE BEEN TRAINED AND ARE QUALIFIED TO DO SO WELL. IT IS THE RESPONSIBILITY OF THE CONGRESS TO BE

ACCOUNTABLE TO THE CITIZENS OF THIS COUNTRY, INCLUDING OUR NATION'S VETERANS, FOR THE SCOPE OF MEDICAL CARE PROGRAMS PROVIDED IN OUR VA MEDICAL FACILITIES. AT THE SAME TIME IT IS THE APPROPRIATE ROLE OF THE CONGRESS AND MY COMMITMENT AS CHAIRMAN OF THIS VETERANS' AFFAIRS COMMITTEE TO OVERSEE THE VA'S MORE THAN $8 BILLION MEDICAL CARE BUDGET. IN THIS REGARD, I CONTINUE TO SEEK A DIALOGUE ON THE SERVICES IT PROVIDES, WHAT SERVICES IT FEELS IT SHOULD CONTINUE TO PROVIDE, AND THE IMPLICATIONS OF THESE VIEWS FOR THE FUTURE OF THE SYSTEM. IN THE FINAL ANALYSIS, WE WILL NOT ALWAYS AGREE. BUT I WOULD HOPE THAT WE WILL CONTINUE TO WORK TOGETHER IN A SPIRIT OF COOPERATION. IT IS WITH THESE QUESTIONS IN MIND THAT WE CONSIDER THE SEVERAL PROPOSALS BEFORE THE COMMITTEE TODAY. THE PROVISIONS IN THE TWO BILLS I INTRODUCED THAT WILL BE CONSIDERED TODAY HAVE BEEN DESIGNED TO EMPHASIZE QUALITY OF CARE AS WELL AS STREAMLINING AND IMPROVING VA PROGRAMS AND THE AGENCY'S AUTHORITY TO MANAGE HEALTH CARE FOR ELIGIBLE VETERANS. ONE PROPOSAL IS S. 2514 IS A MEASURE WHICH WOULD PROMOTE MORE CONCENTRATED EFFORTS TO FOCUS ON AND COORDINATE COMPLEX TYPES OF CARE IN

EFFICIENT WAYS BY TARGETING HEALTH CARE RESOURCES AND APPROPRIATE SERVICES TO MATCH THE VETERAN'S SPECIFIC NEEDS. THE SPECIFIC VETERANS POPULATIONS WHICH WOULD BENEFIT MOST DIRECTLY FROM THIS LEGISLATION WOULD BE THOSE SERVICE-CONNECTED VETERANS, ELDERLY VETERANS, VIETNAM VETERANS WITH POST-TRAUMATIC STRESS DISORDER (PTSD), VETERANS WHO ARE TOTALLY DEAF, AND VETERANS WITH ALCOHOL-RELATED DISORDERS. ONE PROVISION IN S. 2514 WOULD PROVIDE THE VA WITH SPECIFIC AUTHORITY TO COORDINATE AND MAKE ARRANGEMENTS FOR THE PROVISION OF REFERRAL SERVICES TO ASSIST VETERANS IN OBTAINING HEALTH AND HEALTH-RELATED SERVICES FROM SOURCES OUTSIDE THE VA IN ORDER TO SUPPLEMENT THE SERVICES PROVIDED TO THESE VETERANS BY THE VA. THIS PROVISION WOULD PLACE A GREATER PRIORITY ON THE VA'S EFFORTS TO REFER AND ARRANGE FOR COMMUNITY SERVICES FOR SERVICE-CONNECTED VETERANS, ELDERLY VETERANS, AND VETERANS WHO LIVE IN RURAL AREAS WHO COULD BENEFIT FROM ALREADY EXISTING COMMUNITY SERVICES.

ANOTHER PROVISION OF S. 2514 WOULD REQUIRE THE VA TO PRESCRIBE REGULATIONS ESTABLISHING THE PARAMETERS OF THEIR TREATMENT AND REHABILITATION EFFORTS FOR ALCOHOL AND DRUG

DEPENDENCE OR ABUSE DISABILITIES. THE PURPOSE OF THIS PROVISION WOULD BE TO FOCUS ON THE VA'S EFFORTS TO CARE FOR VETERANS WITH THESE DISABLING DISABILITIES AND ENCOURAGE THE VA TO COORDINATE ITS CARE AND TAKE A HARD LOOK AT HOW IT MIGHT IMPROVE AND UNIFY THE TREATMENT MODALITIES IN ITS 102 ALCOHOL TREATMENT UNITS.

THE THIRD PROVISION IN S. 2514 WOULD PROVIDE THE VA WITH SPECIFIC AUTHORITY TO PROVIDE TELECAPTIONING TELEVISION DECODERS AS A MEDICAL DEVICE FOR THE HEARING IMPAIRED IN THE CASE OF ANY VETERAN WHO IS TOTALLY DEAF.

THE FOURTH PROVISION OF S. 2514 WOULD REQUIRE THE VA TO ESTABLISH A POSITION OF ASSOCIATE DIRECTOR FOR POST TRAUMATIC STRESS DISORDER (PTSD) WHO WOULD DEVELOP POLICIES, PROVIDE GUIDANCE AND COORDINATE THE PROVISION OF SERVICES FOR THE TREATMENT OF VIETNAM VETERANS WITH PTSD. THE VA HAS MANY EFFORTS UNDERWAY IN THIS REGARD AT THE LOCAL MEDICAL FACILITIES. THIS PROVISION WOULD REQUIRE THAT THE VA CENTRAL OFFICE PLAY A MORE DIRECT ROLE IN THE DELIVERY OF SUCH CARE.

FINALLY, S. 2514 WOULD REQUIRE THE VA TO SUBMIT A REPORT

TO CONGRESS ON ITS PROGRAMS FOR TREATING VETERANS WHO ARE TERMINALLY ILL AND ON ITS PROGRAMS FOR CARING FOR VETERANS WHO ARE CHRONICALLY ILL AND COULD BENEFIT FROM RESPITE CARE.

WE WILL ALSO HEAR TESTIMONY ON S. 2210 WHICH WOULD CLARIFY THE VA'S AUTHORITY TO PROVIDE AUTOMOBILE ADAPTIVE EQUIPMENT TO CERTAIN SERVICE-CONNECTED VETERANS TO PERMIT SAFE OPERATION OF A MOTOR VEHICLE. THIS PROVISION PROVIDES THAT AN ELIGIBLE VETERAN MAY NOT RECEIVE MORE THAN ONE AUTOMOBILE IN A 3-YEAR PERIOD.

AND SO WE SEEK YOUR TESTIMONY TODAY IN ORDER TO BENEFIT FROM YOUR EXPERIENCE AND KNOWLEDGE IN THESE MOST IMPORTANT AREAS SO THAT WE MAY IMPROVE THE VA HEALTH CARE SYSTEM AND ITS ABILITY TO DELIVER HIGH QUALITY SERVICES IN A COST-EFFECTIVE MANNER AND TO PROVIDE THE MOST APPROPRIATE KINDS OF SERVICES IN A HIGH QUALITY WAY.

BECAUSE OF THE NUMBERS OF ISSUES THAT WILL BE DISCUSSED AT TODAY'S HEARING, I REQUEST THAT YOU SUMMARIZE YOUR STATEMENTS IN NO MORE THAN 5 MINUTES AND HIGHLIGHT THE ONE OR TWO ISSUES MOST IMPORTANT TO YOU. WE WILL THEN ALLOW FOR 10 MINUTES PER MEMBER FOR QUESTIONS ON THE FIRST ROUND, AND ADDITIONAL 10

MINUTE PERIODS FOR QUESTIONING THEREAFTER. THE ENTIRE STATEMENTS OF THE WITNESSES WILL BE INCLUDED IN THE RECORD AT THE APPROPRIATE PLACE. THE COMMITTEE WILL ALSO SUBMIT ADDITIONAL QUESTIONS TO SEVERAL WITNESSES IN WRITING, AND I ASK WITHOUT OBJECTION THAT THOSE QUESTIONS AND RESPONSES BE INSERTED IN THE FINAL HEARING RECORD AT THE APPROPRIATE POINT. SEVERAL WITNESSES HAVE BEEN ASKED TO SUBMIT THEIR VIEWS IN WRITING, AS WE BELIEVE THEIR PERSPECTIVES WILL ADD TO THE COMMITTEE'S CONSIDERATION OF THE MATTERS TO BE ADDRESSED TODAY. THESE WITNESSES, WHOSE TESTIMONY WILL BE INCLUDED IN THE FINAL HEARING RECORD ARE AMVETS, THE VIETNAM VETERANS OF AMERICA, AND OTHERS.

Chairman **Simpson**. Let me recognize now my fine ranking member of this full committee, Senator Cranston.

Senator **Cranston**. I thank our fine chairman for that recognition.

Chairman **Simpson**. I could have done a little better.

Senator **Cranston**. Good morning; I am very pleased to welcome all of you to today's hearing of the Committee on Veterans 'Affairs. I will be carefully reviewing all of your testimony.

Mr. Chairman, in view of the very full schedule for this hearing, I would like to summarize my opening statement and ask unanimous consent that it be printed in the record as if read in full.

Chairman **Simpson**. Without objection, so ordered.

Senator **Cranston**. I place a high priority on the maintenance of a strong, independent VA health-care system capable of providing quality care that is responsive to the particular needs of our Nation's veterans. Thus, I am pleased that we have this opportunity to examine the question of what legislative actions this committee should be taking in the near future to ensure that the VA system is capable of carrying out its vitally important mission most effectively.

As the author of two of the measures before the committee today—S. 2269 and amendment No. 2850 to that bill, both of which are cosponsored by Senators Randolph, Matsunaga and DeConcini—I will, of course, be very interested in the witnesses' views on those measures, as well as on Chairman Simpson's health bill, S. 2514, and other bills scheduled for this hearing.

I described the provisions of S. 2269 and amendment No. 2850 in detail in my floor statements at the time I introduced them and ask unanimous consent, Mr. Chairman, that both those measures and my introductory remarks on them appear in the hearing record at an appropriate place.

Chairman **Simpson**. Without objection, so ordered.

Senator **Cranston**. In my full written statement for today's hearing, I have noted highlights from these two measures about which I particularly welcome input from our witnesses. These provisions would: First, enhance the VA's ability to assist Vietnam-era veterans and certain others—such as those who served in combat-like situations, including in Beirut—who might be suffering continuing psychological problems related to their military service; second, through a change that would affect the VA's readjustment counseling program along with other VA mental health services and hospice care, authorize the VA to continue to provide mental health counseling and other services to surviving family members of a veteran for up to 6 months after the veteran's death if, prior to the veteran's death, they were receiving such services in connection with the veteran's care and treatment by the VA; third, require the VA to establish a nationwide center for research into, and the training of health-care personnel in, the diagnosis and treatment of post-traumatic-stress disorder [PTSD] and the dissemination of relevant information about PTSD throughout the VA system; fourth, improve the VA's ability to attract and retain security services personnel at VA medical centers; fifth, require appropriate executive branch agencies to report to the Congress on how the Federal Government might respond to the needs of individuals who served as civilians in Vietnam for health problems that may be related to their work there; and sixth, specify that any remuneration received by VA patients in certain VA rehabilitation therapy programs shall not be counted as income for the purpose of VA pension programs.

Again, I thank all the witnesses for their participation and am particularly grateful to the VA, The American Legion, the Veterans of Foreign Wars, and the Paralyzed Veterans of America for the support they have provided for most of the provisions of my legislation. I look forward to working with the chairman and other members of the committee to develop a consensus on legislation drawn from the various bills before the committee.

Al, because we would have to report such legislation prior to May 15, I hope before the end of this week we can settle on a date for a markup and get it on the committee's schedule.

Two additional points: Mr. Chairman, with respect to the issue of automobile adaptive equipment, I want to note how strongly I share the sentiments of the PVA as presented in their written testimony, and I congratulate them on their very constructive recommendations on this question. The need for a dependable means of backup transportation to a severely disabled veteran seems to me essential. And I think this should be provided for regardless of the veteran's marital status.

In this regard, after reviewing the VA's testimony on S. 2210 and that of the PVA, the DAV, the VFW, and the Legion, I think a compromise result might well be to permit an eligible veteran to receive two VA equipment adaptions in any 3-year period as part of which the veteran would also be permitted to maintain a second VA-adapted vehicle for backup purposes. I will be requesting the views in writing of the VA and the veterans' organizations on this approach.

Al, Mr. Joseph Collins, executive director of the California Association of Alcoholic Recovery Homes, has submitted a very fine statement for the record of today's hearing. Earlier, Mr. Collins had written to me and on March 13 I wrote to Dr. Custis, asking his views on the materials Mr. Collins had sent me, particularly the results of a survey his association had done regarding its members' experience under the VA pilot program. Yesterday, I received a reply from the VA supporting making the halfway house authority permanent and ask unanimous consent that my letter and Dr. Custis' recent reply be reprinted at an appropriate place in the record.

Chairman SIMPSON. Without objection, so ordered.

Finally, Al, I just want to say I have numerous questions for today's witnesses that will be in writing and ask that you direct that they be returned by the close of business on April 19.

Chairman SIMPSON. That is a perfectly appropriate request, so ordered. Thank you very much.

[The prepared statement of Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follows:]

PREPARED STATEMENT OF HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Good morning. I am very pleased to welcome all of you to today's hearing of the Committee on Veterans' Affairs. The Committee is grateful to those of you who are testifying for your willingness to appear before us today and give us your views on the legislation pending before the Committee. I will be carefully reviewing your testimony.

The maintenance of a strong, independent VA health-care system capable of providing quality care that is responsive to the particular needs of our Nation's veterans has been and is a matter of high priority for me. Thus, I am pleased that we have this opportunity to examine the question of what legislative actions this Committee should be taking in the near future to ensure that the VA system is capable of carrying out its vitally important mission most effectively.

As the author of two of the measures before the Committee today, S. 2269, introduced on February 7, 1984, and Amendment No. 2850 to that bill, introduced on March 27, I will of course be very interested in the witnesses' views on those measures, as well as on Chairman Simpson's health bill, S. 2514, and other bills scheduled for this hearing.

I described the provisions of S. 2269 and Amendment No. 2850 in detail in my floor statements at the time I introduced those measures and ask unanimous consent that both those measures and my introductory remarks on them appear in the hearing record at an appropriate place.

I'd like to highlight some of the provisions of the two measures I introduced with the cosponsorship of Senators Randolph, Matsunaga, and DeConcini.

- First, a group of provisions that I'd like to highlight, in S. 2269 and Amendment No. 2850, are intended to enhance the VA's ability to assist Vietnam-era veterans and others who might be suffering continuing psychological problems related to their military service. Among these provisions is one, contained in Amendment No. 2850, that would require the VA to establish a national center for research into, and the training of health-care personnel in, the diagnosis and treatment of post-traumatic stress disorder -- PTSD -- and the dissemination of relevant information about PTSD throughout the system.

PTSD is a psychiatric disorder that is particularly prevalent among veterans who have seen combat, and most experts who have studied the issue believe that, because of the circumstances of the Vietnam war, including the reaction in our society to the war and its warriors, PTSD is especially prevalent among Vietnam combat veterans. Although the VA has made some strides in PTSD diagnosis and treatment programs, I am convinced that the agency could be and should be doing much more and doing so in a much more coordinated fashion.

It is for this reason that I am advocating that the agency be mandated to establish a PTSD research, training, and information center. In this regard, I welcome the intent of the proposal recently made by the Chairman in S. 2514 to promote greater action on the VA's part on the PTSD issue, and I look forward to developing with him and other members of the Committee a consensual approach to meeting our shared concerns in this area.

The other S. 2269 provisions, relating to the VA's efforts to assist Vietnam-era and other veterans who might be suffering continuing post-service psychological problems, deal directly with the VA's readjustment counseling program, the so-called "Vet Center" program, and more specifically with eligibility to receive readjustment counseling services. Specifically, I'm proposing that four new categories of individuals be made eligible for readjustment counseling: First, persons who served during the Vietnam era but who are still on active duty, and thus not "veterans" under the title 38 definition, would be made eligible for such services; second, by virtue of a proposed change to the starting date of the Vietnam era, individuals who served in Vietnam after July 8, 1959, but before August 5, 1964, the starting date for the Vietnam era in current law, would become eligible for readjustment counseling services; third, the Administrator would be authorized to extend eligibility for such services to individuals who, while serving in the Armed Forces after May 7, 1975, the ending date for the Vietnam era, were exposed to hostile fire in circumstances comparable to wartime conditions; and fourth, in a change that would affect the readjustment counseling program along with other VA mental health services, the VA would be authorized to continue to provide mental health counseling and other services to surviving family members of a veteran for up to six months after the veteran's death if, prior to the veteran's death, they were receiving such services in connection with the veteran's care and treatment by the VA.

In addition to authorizing the VA to provide certain services through the readjustment counseling program, this last proposed change would allow the VA to continue to provide services to a veteran's family in situations, such as in the VA's experimental hospice activities, in which the VA is providing health care to eligible veterans suffering from a terminal illness. An appropriate, integral part of a program of hospice care is counseling for family members both prior to and after the veteran's death and this proposed amendment would provide a clear statutory basis for the VA to provide such counseling following the veteran's death. Again, I note that the Chairman has proposed a hospice report in his bill, and I look forward to integrating our efforts in this respect.

- Second, both S. 2269 and Amendment No. 2850 contain provisions designed to improve the VA's ability to attract and retain personnel -- protective services officers -- who provide security at VA medical centers. As has been noted by many familiar with the VA -- particularly the various veterans' service organizations, such as The American Legion through its field service officers' visits to VA facilities -- the VA has had and continues to have significant difficulties in this regard, particularly at some larger VA medical centers located in urban areas. As a result, the level of security at many VA facilities has suffered as has the morale of VA protective services officers. In this regard, I note that The Legion has prepared a useful summary, based on their field service officers visits, of the security situation around the DM&S system,for which I am very grateful. I ask unanimous consent that this summary appear in the hearing record at an appropriate place.

The provisions in the two measures that address this problem would give the Administrator new authority to modify rates of pay for these personnel; clarify the Administrator's authority to designate individuals to serve as VA protective services officers; require the Administrator to issue regulations relating to such employees' authority to make arrests, the content and duration of their training, limitations on the carrying and use of weapons, and other law enforcement matters; and authorize a special clothing allowance for VA protective services officers.

Taken together, these provisions should help correct the problems the VA is facing in recruiting and retaining security personnel.

- Third, a further provision in S. 2269, like those I described earlier, also relates to the Vietnam conflict. It concerns not veterans of that conflict but, rather, those individuals who served in Vietnam as civilians, either as Government employees or as employees of organizations, such as the American Red Cross or the USO, that provided significant assistance to our Armed Forces. Under this provision, the Administrator of Veterans' Affairs, in conjunction with the Secretary of Defense and the Secretary of Health and Human Services, would be required to submit a report to the Congress on how the Federal Government might respond to the needs of these individuals for health problems related to their work in Vietnam, such as for disabilities that might be related to their exposure to dioxin in Agent Orange or to particularly stressful situations.

This report should help provide guidance on how the Federal Government might provide assistance to the many individuals who made important contributions to the U.S. efforts in Vietnam but who, because of their non-military or non-federal status during that period, generally do not now have access to assistance from the Federal Government for problems that might be related to their work in Vietnam.

- A final provision that I wish to highlight, which is contained in Amendment No. 2850, would specify that any remuneration received by VA patients in a rehabilitation therapy program under section 618 of title 38, United States Code, shall not be counted as income for the purpose of VA pension programs. Under section 618, the VA is authorized to conduct programs of rehabilitation and therapy under which participants -- VA patients selected for such programs -- perform services for which they receive a small payment. Known commonly as incentive therapy and compensated work therapy, the primary emphasis of these programs is on the therapeutic benefit of the work performed and the fact that patients have an incentive to participate in this rehabilitative program because they receive some payment for it.

Earlier this year, a change was made in the program whereby the payments veterans are receiving for their work in these programs are being counted as income to the veterans for the purpose of determining their entitlement to VA pension. For many of these veterans who are in receipt of VA pension, this change has the effect of reducing their pension benefits by an amount equal to the amount they are receiving under incentive or compensated work therapy. This change has already had the entirely predictable result of discouraging participation in these therapy programs by those in receipt of VA pension.

To avoid this result, the provision in Amendment No. 2850 would amend section 618 of title 38 to specify that payments to participants in programs carried out under that section are not to be counted as income for the purposes of VA pension.

Again, I thank all the witnesses for their participation. I look forward to working with the Chairman and other members of the Committee as we develop legislation from the various bills before the Committee.

Chairman **Simpson**. George Mitchell, please; Senator Mitchell of Maine. We are glad to have you here, George.

Senator **Mitchell**. Thank you, Mr. Chairman. I join with you and Senator Cranston in welcoming those who will present testimony this morning on the important issue of veterans' health-care services.

I especially want to thank you, Mr. Chairman, for allowing me to have the topic of rural health-care services included among the topics to be addressed today. I am grateful to Senator Cranston for his support of my efforts regarding rural health-care services.

As you know, the delivery of VA health-care services to veterans living in rural, geographically remote areas is an issue of great significance to many veterans in Maine and throughout the country. Of the 153,000 veterans now living in Maine, over half, or about 53 percent of them, live in rural areas.

Last year I introduced legislation which would require the Administrator to establish an experimental program to determine the feasibility of furnishing diagnostic health-care services to veterans living in rural areas. My legislation was the subject of a hearing before this committee last July, which I feel clearly demonstrated the need for pilot program efforts on the part of the VA to upgrade health-care delivery to rural veterans living in Maine.

At the same time, I believe the hearing demonstrated the lack of a centrally directed effort on the part of the VA to determine the extent of similar problems facing rural veterans nationwide, much less, any concerted efforts on the part of the VA to address any problems which might exist. Following that hearing, my colleague, Senator Cohen, and I agreed to work together to develop two-track legislation which would address the present shortcomings in the delivery of rural health-care services to veterans. The first track would set in motion efforts to gather statistics which would enable this committee to accurately assess the health-care needs of America's rural veterans. The second track would authorize a pilot program.

In February, we made our intentions known to the leadership of this committee when I wrote to the chairman and ranking member. At this committee's hearing on the VA's fiscal 1985 budget, I again raised the issue of rural health care.

In an attempt to facilitate the VA's compilation of evidence for presentation in today's written testimony, I wrote to Administrator Walters with a detailed list of issues I wished to be addressed. Unfortunately, the Administrator has since informed me, that because of the detail required in answering my questions, the VA would not be able to provide responses in its presentation today.

I believe it is important that the record of today's hearing include what we have so far on the various issues that I asked the VA to address in its written statement. So if there is no objection, Mr. Chairman, I would ask that my complete opening statement, my February 3 letter to you and Senator Cranston, the March 13 letter from Senator Cranston to you, my March 29 letter to Administrator Walters, and his April 6 response to me, be made a part of the record of this hearing.

I will pursue it to the extent that I can with these witnesses in questions.

Chairman SIMPSON. Without objection, so ordered.

Senator MITCHELL. I do want to say, Mr. Chairman, I do have a very unfortunate schedule conflict. At this very moment, the Environment and Public Works Committee, on which you also serve, is holding a hearing on legislation which I have introduced. I will not be able to remain for this entire hearing, but I apologize in advance to those witnesses whose testimony I will not hear. I assure you that I will review their statements very carefully, along with all the record of this hearing.

I thank you, Mr. Chairman.

Chairman SIMPSON. Thank you. I appreciate your being here.

[The prepared statement of Hon. George J. Mitchell, a U.S. Senator from the State of Maine, follows:]

PREPARED STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM THE STATE OF MAINE

Thank you Mister Chairman. I join with you and Senator Cranston in welcoming those who will present testimony this morning on various aspects of veterans' health-care services. It is a topic with which I have great interest and I look forward to hearing from the distinguished expert witnesses.

I also want to thank you, Senator Simpson, for allowing me to have the topic of rural health-care services included among the topics to be addressed by the VA today. And I am grateful to my friend, Alan Cranston, for his support of my efforts regarding rural health.

As you know, the delivery of VA health-care services to veterans living in rural, geographically remote areas is an issue which holds great significance to thousands of veterans in Maine. Over 153,000 veterans reside in the State of Maine, of whom 14% are aged 65 years or older. According to 1980 U.S. Bureau of Census figures, 53% of all veterans in Maine reside in rural areas. The VA Medical Center at Togus, near Augusta, is the only health care facility for Maine veterans in the entire state. Access to outpatient care under VA auspices for Maine veterans is, therefore, hampered due to the geographical distances involved in travelling to and from Togus.

Recognizing that, I introduced legislation, S.523, which would require the Administrator to establish an experimental program to determine the feasibility of furnishing diagnostic health-care services to veterans living in certain areas of Maine. My legislation was the subject of a hearing by this Committee on July 13, 1983, which I feel clearly demonstrated the need for pilot-program efforts on the part of the VA to upgrade health-care delivery to rural veterans living in Maine.

At the same time, I believe the hearing demonstrated the lack of a centrally-directed effort on the part of the VA to determine the extent of similar problems facing rural veterans nationwide, much less, any concerted efforts on the part of the VA to address any problems which might exist. That is troubling to me, especially in light of what is already known about the delivery of health-care in rural areas.

A Research Service Task Force report in 1980 showed that while rural areas in the U.S. contain over 30% of the nation's population, they offer the resources of only 12% of the nation's total available physicians. The Task Force also found residents of non-metropolitan areas are less likely to obtain preventive care, are more likely to spend more than 30 minutes traveling to their source of care, and experience longer waits for attention once they arrive at the point of medical treatment.

The ramifications of these problems have been investigated by the VA and reported in "Report on the Aging Veteran" (USVA, 1978). It has been determined that the older veteran, especially a rural resident finds it difficult to obtain longitudinal outpatient care. Lack of transportation and of treatment coordination between outpatient and inpatient service sites are the principal barriers facing older, rural veterans. Despite that, in response to a question submitted by the Chairman following the July 1983 hearing, the VA said it had no specific policy guidance with regard to dealing with the provision of care to veterans living in "remote areas". The VA was unable to provide this Committee any examples of specific guidance from Central Office to individual VA Medical Centers regarding the establishment of alternative services for veterans who live in rural areas. The VA was unable to provide any data on the number of veterans living various distances from VA Medical Centers and their utilization of VA Medical services.

Following that hearing, my colleague, Senator Cohen, and I agreed to work together to develop two-track legislation which would address the present shortcomings in the delivery of rural health-care services to veterans. The first track would set in motion efforts to gather statistics which would enable this Committee to accurately assess the health-care needs of America's rural veterans. The second track would authorize a pilot program in Maine.

In February, we made our intentions known to the leadership of this Committee when I wrote to the Chairman and Ranking Member. (a copy of the letter to be printed following this statement) I was pleased to see the Ranking Member support ~~for~~ my efforts to have the issue of rural health-care addressed at today's hearing (a copy of Senator Cranston's letter to be printed following this statement). At this Committee's hearing on the VA's FY85 Budget, I again raised the issue of rural health-care.

In an attempt to facilitate the VA's compilation of evidence for presentation in today's written testimony, I wrote to Administrator Walters with a detailed list of issues I wished to be addressed. Unfortunately, the Administrator has since informed me that because of the detail required in answering my questions, the VA would not be able to provide responses in its presentation (copies of both letters to be printed following this statement).

Never-the-less, I intend to question the representatives from the VA about several aspects of rural health-care at today's hearing. I hope the VA's written responses to my questions will be available shortly so that Senator Cohen and I can move quickly to draft a national veteran's rural health care bill.

ALAN K. SIMPSON, WYO., CHAIRMAN
STROM THURMOND, S.C.
ROBERT T. STAFFORD, VT.
FRANK H. MURKOWSKI, ALASKA
ARLEN SPECTER, PA.
JEREMIAH DENTON, ALA.
RUDY BOSCHWITZ, MINN.
ALAN CRANSTON, CALIF.
JENNINGS RANDOLPH, W. VA.
SPARK M. MATSUNAGA, HAWAII
DENNIS DECONCINI, ARIZ.
GEORGE J. MITCHELL, MAINE

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, D.C. 20510

February 3, 1984

Honorable Alan K. Simpson, Chairman
Honorable Alan Cranston, Ranking
   Minority Member
Committee on Veterans Affairs
United States Senate
Washington, D.C. 20510

Dear Al and Alan:

Your letter of January 30 solicited recommendations from Committee members for additions to the proposed Committee agenda and hearing/markup schedule for the coming year. I am writing to request that S.523, a bill which I introduced last year, be placed on the agenda for the markup scheduled for May 2.

As you know, S.523, which addresses the health care needs of veterans living in remote rural areas of Maine, was the subject of a hearing held by the Committee on July 13, 1983.

That hearing convinced me that the shortcomings in the delivery of health care services to rural veterans in Maine which prompted my bill were found in other areas of the country. My colleague Senator Cohen, was among those testifying in support of a national approach to rural veterans health care services. Subsequently, we agreed to work together in developing legislation which would expand the pilot program contained in S.523 into a national pilot program. It is my intention to offer that legislation as an amendment to S.523 during markup.

Honorable Alan K. Simpson
Honorable Alan Cranston
Page Two
February 3, 1984

Additionally, because a VA evaluation of present rural health care delivery alternatives would be helpful in drafting such legislation, I also request that the topic of rural health care services be included at the Committee's April 4 legislative hearing on health.

Thank you for your consideration of my requests. As always, I look forward to working closely with you both in the months ahead.

Sincerely,

George J. Mitchell

George J. Mitchell
United States Senator

ALAN K. SIMPSON, WYO., CHAIRMAN
STROM THURMOND, S.C.
ROBERT T. STAFFORD, VT.
FRANK H. MURKOWSKI, ALASKA
ARLEN SPECTER, PA.
JEREMIAH DENTON, ALA.
RUDY BOSCHWITZ, MINN.
ALAN CRANSTON, CALIF.
JENNINGS RANDOLPH, W. VA.
SPARK M. MATSUNAGA, HAWAII
DENNIS DE CONCINI, ARIZ.
GEORGE J. MITCHELL, MAINE

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, D.C. 20510

March 13, 1984

Honorable Alan K. Simpson
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Al,

I am writing in support of Senator Mitchell's request in his February 3 letter to us that the topic of rural health-care services be included in the Committee's April 4 legislative hearing on health-care issues.

Many of our constituents in California and Wyoming reside in remote areas -- as do George's in the northern parts of Maine -- and I am sure you share the view that access to health care for veterans in rural areas requires careful evaluation. Thus, I hope that the Committee will examine this issue in greater detail at the April 4 hearing.

With warm regards,

Cordially,

Al

Alan Cranston
Ranking Minority Member

cc: Honorable George J. Mitchell

GEORGE J. MITCHELL
MAINE

United States Senate
WASHINGTON, D.C. 20510

March 29, 1984

Mr. Harry N. Walters
Administrator
Veterans Administration
Washington, D.C. 20420

Dear Harry:

As you know, the delivery of VA health-care services to veterans living in rural, geographically remote areas is an issue which holds great significance to thousands of veterans in Maine. Recognizing that, I introduced legislation, S.523, which would require the Administrator to establish an experimental program to determine the feasibility of furnishing diagnostic health-care services to veterans living in certain areas of Maine. My legislation was the subject of a hearing by the Veterans' Affairs Committee on July 13, 1983, which I feel clearly demonstrated the need for pilot-program efforts on the part of the VA to upgrade health-care delivery to rural veterans living in Maine and failed to show the lack of need for national legislation at this time.

Following that hearing, my colleague, Senator Cohen, and I agreed to work together to develop two-track legislation which would address the present shortcomings in the delivery of rural health-care services. The first track would set in motion efforts to gather statistics which would enable this Committee to accurately assess the health-care needs of America's rural veterans. The second track would authorize a pilot program in Maine. It is our intention to offer this two-track legislation as an amendment to my bill, S.523, during the Committee markup of health legislation. Your attention to the following points as part of the VA's prepared statement and during the course of the VA's testimony at the Committee hearing on April 11 would aid Senator Cohen and me in drafting legislation.

In response to written questions 4 and 5 which I submitted to the VA following the Committee's July 13, 1983, oversight hearings, the VA was unable to provide statistics regarding the number of veterans residing various distances from VA medical facilities. In response to written question 1a which I submitted to the VA following the Committee's February 8 Budget hearing, the VA said this kind of information could be developed by two full-time employes over a 9-12 month period.

a) What technical expertise is needed to develop national statistics on rural veteran populations? Does the VA have the technical capacity in-house to develop national statistics on veteran populations residing various distances from VA medical facilities (questions 4 and 5) along the lines which the Togus VAM&ROC provided me regarding Maine veterans (see letter from Togus Center Director John Bunger, page 54, S.Hrg. 98-456). If not, how would the VA acquire this capacity?

b) What would be the dollar costs to the VA of developing such statistics and what would be the value of such statistics to the VA in evaluating the availability of present VA health care delivery programs to rural veterans.

c) Do you feel such statistics mentioned above could be used by this Committee to target possible pilot VA program health-care delivery alternatives? What additional data would be helpful to the Committee in this regard?

In response to written question 1d, which I submitted to the VA following the February 8 hearing, the VA identified various alternative ways to provide health-care services to geographically remote veterans. Within the VA's written testimony, please provide more detail, with emphasis on the applicability of these projects to rural health care in Maine, on those alternatives listed in answer 1d which have been identified as having a current annual support in excess of $100,000 (St. Cloud VAMC: COPE; Hot Springs VAMC: outreach to Rushville, Nebraska; Denver VAMC: Medivan; Salt Lake City VAMC: Outreach to Richfield and Roosevelt; and Tuscaloosa VAMC-Community Service Program).

I am especially interested in the efforts in Richfield and Roosevelt on the part of the Salt Lake City VAMC. Those clinics have been operational for over one year now and continued funding by the VA would indicate that health-care service delivery by those clinics to veterans has been reviewed and seen to be both high quality and cost-effective. Please advise me of any modifications to the operation of those outreach efforts from the descriptions provided by Salt Lake City Center Director Robert E. Lindsey in his prepared statement for the July 13, 1983 hearing (p.126-137, S.Hrg. 98-456).

In your letter to the Chairman of July 11, 1983, you presented the VA's view of S.523 (p. 19-22, S.Hrg. 98-456).

a) To what degree does the Salt Lake City VAMC find it necessary to rediagnose veterans referred by the Richfield and Roosevelt clinics?

b) Have the operation of the clinics presented misleading impressions to nonservice-connected veterans regarding eligibility for VA treatment? What problems has the VA encountered in making accurate eligibility determinations and properly monitoring the provision of quality care?

c) Can the VA provide me a detailed breakdown of expenditures associated with a diagnostic clinic which would result in a 3-year $980,000 expenditure that would be generated by enactment of S.523?

In response to written question 1g which I submitted to the VA following the Committee's February 8 hearing, the VA referred to a project, #82-113, entitled, "Cost-effectiveness of Rural Health Centers in Providing Care for Veterans (Togus, Maine)", as an example of Investigator-Initiated Research devoted to improving health-care service delivery to rural veterans.

a) At what date can we expect final approval of this project by the VA? Is it the impression of the VA that the $105,000 FY85 funding estimate included for this project in response 1g will be sufficient? Is the VA committed to funding for the expected 5-year life of this study? If so, at what level of funding for each year?

b) Under the parameters of the study, would it be possible to include Aroostook County among the areas included in this study? Would a mandated inclusion of Aroostook County jeopardize the scientific validity of this study?

c) It is my understanding that as part of this research, veterans living in geographically remote areas of Maine will be encouraged to utilize the services of rural health clinics which have entered into "federation agreements" with Togus VAM&ROC. How would such "federation agreements" differ from the contractual agreement central to S.523?

I understand that Senate Veterans' Affairs Committee rules require written testimony to be submitted at least 48 hours prior to a hearing. I request a copy of that testimony when it is made available to Committee staff.

Mr. Harry N. Walters
March 29, 1984
Page 4

I look forward to receiving, as part of the VA's testimony, answers to the questions raised in this letter. I remain hopeful that you will join Senator Cohen and me in supporting legislation to seek creative, innovative methods to improve health-care service delivery to this country's geographically remote veteran population.

Sincerely,

George J. Mitchell

George J. Mitchell
United States Senator

cc: Senator Simpson
Senator Cranston
Senator Cohen
Rep. Snowe

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

APRIL 6- 1984

Honorable George J. Mitchell
United States Senate
Washington, D.C. 20510

Dear Senator Mitchell:

Thank you for your letter of March 29, 1984, advising me of your continuing interest in the subject of the health care of rural veterans and requesting that we address certain specific questions on this subject as part of our prepared statement for the Senate Veterans' Affairs Committee hearing on April 11.

The questions you raised are incisive and will require extensive staff work. Moreover, as you know, many of these questions involve programs initiated at individual VA medical centers, and will require coordination with those centers as well as with regional medical officials. Under the circumstances, I regret that it will not be possible to provide answers to your questions in our testimony as you requested. Please be assured that we will respond in full to your questions as soon as possible. In the meantime, VA representatives would, of course, certainly attempt to respond to any questions on this subject you might raise in the course of this hearing.

Sincerely,

Deputy Administrator • For

HARRY N. WALTERS
Administrator

Chairman SIMPSON. Without objection, the prepared statement of Hon. Rudy Boschwitz, a U.S. Senator from the State of Minnesota; the text of the bills S. 2210, S. 2269, amendment No. 2850 to S. 2269, S. 2278, S. 2514; the introductory statements; and agency reports thereon will be entered into the record at this point.

[The prepared statement of Hon. Rudy Boschwitz, a U.S. Senator from the State of Minnesota; the text of the bills S. 2210, S. 2269, amendment No. 2850 to S. 2269, S. 2278, S. 2514; the introductory statements; and agency reports thereon, as referred to earlier, follow:]

PREPARED STATEMENT OF HON. RUDY BOSCHWITZ, A U.S. SENATOR FROM THE STATE OF MINNESOTA

MR. CHAIRMAN, TODAY THIS COMMITTEE WILL HAVE THE OPPORTUNITY TO REVIEW, ALONG WITH OUR WITNESSES, VARIOUS PROPOSALS TO IMPROVE AND UPGRADE VETERANS HEALTH CARE PROGRAMS. INCLUDED ARE SEVERAL PROPOSALS I FEEL ARE VERY IMPORTANT.

OF COURSE, GIVEN PRIDE OF AUTHORSHIP, I FEEL MY BILL, S. 2278, IS THE MOST IMPORTANT BILL UNDER CONSIDERATION! BUT ACTUALLY, I AM VERY PLEASED TO SEE SIMILAR LANGUAGE IN BOTH SENATOR SIMPSON'S AND CRANSTON'S COMPREHENSIVE HEALTH BILLS -- IT CERTAINLY APPEARS THIS COMMITTEE WILL BE ACTING ON THIS ISSUE THIS YEAR.

S. 2278 DEALS WITH THE VA'S AUTHORITY TO PLACE CHEMICALLY DEPENDENT VETERANS IN NON-VA COMMUNITY FACILITIES. CURRENTLY, THIS HALF-WAY HOUSE PROGRAM IS OPERATING UNDER A PILOT AUTHORITY THAT IS DUE TO EXPIRE SEPTEMBER 30, 1985.

MR. CHAIRMAN, I HAVE BEEN IN TOUCH WITH VA OFFICIALS AND VETERANS IN MEDICAL FACILITIES AROUND BOTH MINNESOTA AND THE COUNTRY. THEIR REACTIONS TO THE PROGRAM'S WORTH HAVE BEEN OVERWHELMINGLY POSITIVE. "IT'S THE BEST THING EVER TO HAPPEN TO THE VA'S CHEMICAL DEPENDENCY PROGRAM" IS A TYPICAL COMMENT.

I BELIEVE THIS PILOT PROGRAM SHOULD BE MADE PERMANENT, AND I HOPE MY BILL, OR LEGISLATION INCLUDING IT, IS SPEEDILY REPORTED OUT OF THIS COMMITTEE.

UNFORTUNATELY, THE VA DOES HAVE A WAYS TO GO IN ITS OVERALL TREATMENT OF THOSE SUFFERING FROM ALCOHOL OR DRUG ADDITION. I AM REFERRING SPECIFICALLY TO ITS CONTINUED RESISTANCE TO DELIMITING DATE EXTENSIONS WHEN A VETERAN HAS LOST EDUCATIONAL OR VOCATIONAL ASSISTANCE BECAUSE OF AN ALCOHOL OR DRUG DEPENDENCE, BUT SUBSEQUENTLY RECOVERS.

THE VA TREATS NEARLY 100,000 VETERANS EACH YEAR FOR ALCOHOLISM RELATED PROBLEMS -- SECOND ONLY IN NUMBER TO HEART DISEASE PATIENTS. I WANT TO KNOW WHY, IF THE VA IS WILLING AND ABLE -- RIGHTFULLY SO -- TO PROVIDE MEDICAL ASSISTANCE TO THESE CHEMICALLY DEPENDENT VETS; IT IS EQUALLY WILLING TO CLING TO THE BELIEF THAT A RELATED REQUEST FOR AN EXTENSION OF GI BILL BENEFITS SHOULD BE REJECTED BECAUSE ALCOHOLISM IS "WILLFUL MISCONDUCT"?

IT SEEMS OBVIOUS THAT ONE EXCELLENT WAY OF IMPROVING THE CHANCES THAT A CHEMICALLY DEPENDENT VET STAYS CLEAN IS TO CONTINUE TO PROVIDE EDUCATIONAL AND JOB TRAINING OPPORTUNITIES. THE VA APPEARS ONLY WILLING TO HELP A VET GO CLEAN, AND UNWILLING TO HELP HIM STAY CLEAN. I BELIEVE THIS POLICY IS MISGUIDED, AND I HOPE THIS COMMITTEE CAN ONCE AGAIN TAKE THE LEAD IN AN EFFORT TO CHANGE THIS ANACHRONISM.

II

98TH CONGRESS
2D SESSION

S. 2210

To revise and clarify the eligibility of certain disabled veterans for automobile adaptive equipment.

IN THE SENATE OF THE UNITED STATES

JANUARY 24 (legislative day, JANUARY 23), 1984

Mr. SIMPSON introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

---

A BILL

To revise and clarify the eligibility of certain disabled veterans for automobile adaptive equipment.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 1903(c) of title 38, United States Code, is amended to read as follows:

"(c) An eligible person shall not be entitled to adaptive equipment under this chapter for more than one automobile or other conveyance in a three-year period, except where the Administrator determines, according to standards which the Administrator shall prescribe, that exigent circumstances justify early vehicle replacement.".

[No. 75]

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

MAY 7 - 1984

Honorable Alan K. Simpson
Chairman, Committee on Veterans'
Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman: Al

I am pleased to respond to your request for the views of the Veterans Administration (VA) on S. 2210, 98th Congress, a bill "to revise and clarify the eligibility of certain disabled veterans for automobile adaptive equipment."

Section 1902 of title 38, United States Code, authorizes VA to provide automobile adaptive equipment to certain veterans and servicepersons who suffer from severe service-incurred disabilities to enable them to safely operate an automobile or other conveyance. Currently, under 38 U.S.C. § 1903(c), VA may not provide an eligible person adaptive equipment for more than one automobile or other conveyance at any one time. Thus, a veteran who has transferred title to an adapted vehicle but continues to have the use of that vehicle would not be eligible for VA reimbursement for adaptive equipment on a new vehicle. But currently there is no statutory limitation on how frequently such persons may purchase a new vehicle and obtain new adaptive equipment at VA expense. S. 2210 would remove the bar to transferability and impose a limitation on the frequency with which the VA would reimburse a veteran for adaptive equipment. VA's current policy permits reimbursement for adaptive equipment on up to three vehicles in two years. S. 2210 would amend section 1903(c) to provide that an eligible person may not be provided adaptive equipment for more than one automobile or other conveyance in a three-year period except when exigent circumstances justify early vehicle replacement.

In commenting on this provision, we would stress that very few veterans seek reimbursement for adaptive equipment from the VA on so frequent a basis that it could be termed "abusive." We estimate that most of the eligible veterans do not seek reimbursement more than once in a three-year period, with the average utilization for the last three fiscal years being approximately one vehicle each 6.4 years. Moreover, it is important to note that many of the veterans who trade vehicles more frequently are severely disabled and feel the need for extremely dependable transportation because of the severity of their disabilities.

Nevertheless audits and program evaluations have revealed a few instances where veterans have sought reimbursement for adaptive equipment more frequently than may have been essential. Some of the previously existing excesses in program utilization have already been corrected with the issuance of a DM&S circular, providing guidelines with respect to the administration of the adaptive equipment program. However, in light of the potential for abuse that may still exist in this program, we have no objection to the enactment of S. 2210, but we strongly recommend that it be amended to impose a one-vehicle-in-two-year rather than a one-vehicle-in-three-year restriction. Such a limitation would be somewhat more restrictive than our current guidelines, but would still allow reimbursement on a frequent enough basis to assure dependability in the vehicles used by these extremely handicapped veterans. Even such a restriction, however, would need a provision whereby the Administrator could make exceptions under specific factual circumstances, where true need exists.

The VA estimates that enactment of S. 2210 would result in relatively insignificant cost savings. We have enclosed information as to how we computed the estimated cost savings.

Advice has been received from the Office of Management and Budget that there is no objection to the presentation of this report on S. 2210 from the standpoint of the Administration's program.

Sincerely,

Harry

HARRY N. WALTERS
Administrator

Enclosures

SUPPORTING DATA
AND
COST ESTIMATE

I. Potential Eligible Veterans - Report of Prosthetic Activities (RCS 10-64) Section III, Cumulative Inventory of Active Prosthetic Disabilities, 9/30/83.

Amputees	
Upper Extremity	5,602
Lower Extremity	26,243
Spinal Cord Injury	
Paraplegic	10,245
Quadriplegic	1,421
Brace Cases	
Loss of use of an extremity	2,780
SUBTOTAL	46,291
Ankylosis (DVB statistics)	
Hip	1,634
Knee	3,315
GRAND TOTAL	51,240

II. Veterans Who Avail Themselves of the Benefit - RCS 10-64, FY'77- FY'83.

FY'77 = 9426
FY'78 = 9232
FY'79 = 8462
FY'80 = 9033
FY'81 = 7982
FY'82 = 7984
FY'83 = 7705
59,824 SEVEN YEAR AVERAGE 8546

We believe that more veterans will avail themselves of the benefit in the next few years and that utilization will be closer to the average for the years FY'77 thru FY'80. We base this assumption on the improving economy and recent increases in sales in the automobile industry.

Average high utilization FY'77 thru FY'80 - 1 vehicle each 5.1 years.

Average low utilization FY'80 thru FY'83 - 1 vehicle each 6.4 years.

Average cost per claim FY'83 $1096
($8,446,887 ÷ 7705)

III. Cost Estimate

The available data clearly indicates that the vast number of veterans are not trading their cars frequently. We estimate that only a small number of veterans, 4 or 5%, would trade cars which are less than three years old. The estimated 4 or 5% would account for 5 or 6 claims processed each year at the 75 VA facilities processing automobile adaptive equipment claims. Therefore, we believe that the following estimate is fairly realistic:

Average number of claims high utilzation
(FY'77 thru FY'80) = 9038

Average cost per claim FY'83 $1096

4% of 9038 = 362 x $1096 = $396,752
5% of 9038 = 452 x $1096 = $495,392

Estimated reduction in program costs:

$396,752 to $495,392

10A2 CONCUR Robert P. Dunn for Mr Travers

DO NOT CONCUR _______________

II

98TH CONGRESS
2D SESSION

S. 2269

To amend title 38, United States Code, to improve various aspects of Veterans' Administration health-care programs and to provide eligibility to new categories of persons for readjustment counseling from the Veterans' Administration; and to require the Administrator of Veterans' Affairs and the Secretaries of Defense and of Health and Human Services to submit a report on alternatives for providing Federal benefits and services to individuals who, as civilians, provided services to United States Armed Forces in Vietnam during the Vietnam era; and for other purposes.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 7 (legislative day, FEBRUARY 6), 1984

Mr. CRANSTON (for himself, Mr. RANDOLPH, Mr. MATSUNAGA, and Mr. DECONCINI) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

---

A BILL

To amend title 38, United States Code, to improve various aspects of Veterans' Administration health-care programs and to provide eligibility to new categories of persons for readjustment counseling from the Veterans' Administration; and to require the Administrator of Veterans' Affairs and the Secretaries of Defense and of Health and Human Services to submit a report on alternatives for providing Federal benefits and services to individuals who, as civilians, provided services to United States Armed Forces in Vietnam during the Vietnam era; and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) this Act may be cited as the "Veterans' Administration Health-Care Program Improvements Act of 1984".

(b) Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or a repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

DEFINITION OF VIETNAM ERA

SEC. 2. Section 101(29) is amended to read as follows:

"(29) The term 'Vietnam era' (A) means the period beginning on August 5, 1964, and ending on May 7, 1975, and (B) in the case of a veteran who served in the Republic of South Vietnam during the period beginning on July 8, 1959, ~~and ending~~ on May 7, 1975, means such period.".

SEC. 3. Section 601(6)(B) is amended to read as follows:

"(B)(i) such consultation, professional counseling, training, and mental health services as are necessary in connection with the treatment—

"(I) of the service-connected disability of a veteran pursuant to section 612(a) of this title, and

"(II) in the discretion of the Administrator, of the non-service-connected disability of a veteran eligible for treatment under section 612(f)(1)(B) of this title where such services were initiated during the veteran's hospitalization and the provision of such services on an outpatient basis is essential to permit the discharge of the veteran from the hospital,

for the members of the immediate family or legal guardian of a veteran, or the individual in whose household such veteran certifies an intention to live, as may be essential to the effective treatment and rehabilitation of the veteran (including, under the terms and conditions set forth in section 111 of this title, travel and incidental expenses of such family member or individual in the case of a veteran who is receiving care for a service-connected disability, or in the case of dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title); and

"(ii) in the case of individuals who, by reason of their relationship to such veteran, were recipients of services under subclause (i) of this clause at the time of the death of such veteran, such counseling services, for a period not to exceed six months, as the Administrator determines to be reasonable and necessary to assist such individuals with the emotional and psychological stress accompanying the veteran's death.

For the purposes of this paragraph, a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title shall be eligible for the same medical services as a veteran.".

ELIGIBILITY FOR READJUSTMENT COUNSELING AND RELATED MENTAL HEALTH SERVICES

SEC. 4. Subsection (a) of Section 612A is amended to read as follows:

"(a)(1) Upon the request of—

"(A) a veteran who served on active duty during the Vietnam era,

"(B) a person who is serving on active duty and who also served on active duty during the Vietnam era, or

"(C) a person (i) who is a veteran or is serving on active duty, and (ii) who served on active duty after May 7, 1975, in an area during a period in which hostilities (as defined in paragraph (2) of this subsection) occurred in such area,

the Administrator shall, within the limits of Veterans' Administration facilities, furnish counseling to such veteran or person in readjusting to civilian life.

"(2) For the purpose of paragraph (1)(C) of this subsection, the term 'hostilities' means a situation in which the Administrator, in consultation with the Secretary of Defense, finds that members of the Armed Forces were subjected to danger from armed conflict comparable to the danger to which members of the Armed Forces have been subjected in battle with the enemy during a period of war.".

TREATMENT AND REHABILITATION FOR ALCOHOL OR DRUG DEPENDENCE OR ABUSE DISABILITIES

SEC. 5. (a) Section 620A is amended—

(1) in subsection (a)(1) by striking out "may conduct a pilot program under which the Administrator" and the second sentence; and

(2) by striking out subsection (e) and redesignating subsections (f) and (g) as subsections (e) and (f), respectively.

(b) The heading of such section is amended to read as follows:

"§ 620A. Treatment and rehabilitation for alcohol or drug dependence or abuse disabilities".

(c) The item relating to such section in the table of sections at the beginning of chapter 17 is amended to read as follows:

"620A. Treatment and rehabilitation for alcohol or drug dependence or abuse disabilities.".

VETERANS' ADMINISTRATION PROTECTIVE SERVICES PERSONNEL

SEC. 6. Section 4107(g) is amended—

(1) in paragraph (1)—

(A) by striking out "or" in clause (A);

(B) by striking out the comma and inserting in lieu thereof a semicolon and "or" in subclause (iv) of clause (B); and

(C) by inserting after clause (B) the following new clause:

"(C) of employees providing protective services in buildings under the jurisdiction of the Administrator (and not under the control of the Administrator of General Services) that are used for the purpose of providing health care,";

(2) by striking out "health-care" each place it appears in paragraphs (2)(A) and (4); and

(3) by inserting "or (C)" after "(B)" in paragraph (4).

COMPTROLLER GENERAL REPORT ON MEDICAL PERSONNEL STAFFING LEVELS

SEC. 7. Section 5010(a)([illegible])(C) is amended to read as follows:

"(C) Not later than fifteen days after the expiration of the period for the submission of a certification by the Director of the Office of Management and Budget under subparagraph (B) of this paragraph, the Comptroller General shall submit to the appropriate committees of the Congress a report stating the Comptroller General's opinion as to whether the Director has complied with the requirements of such subparagraph in providing such certification and in providing to the Veterans' Administration such funded personnel ceiling.".

STATE HOME FACILITY GRANT APPLICATION APPROVAL

SEC. 8. Subsection (b) of section 5035 is amended—

(1) by inserting "(1)" before "The";

(2) by inserting a comma and "subject to paragraph (2) of this subsection," after "The Administrator";

(3) by redesignating clauses (1), (2), (3), and (4) as clauses (A), (B), (C), and (D), respectively; and

(4) by adding at the end the following new paragraph:

"(2)(A) In the event that funds appropriated for any fiscal year pursuant to section 5033(a) of this title are not sufficient to make all grants requested that the Administrator would approve during such fiscal year under paragraph (1) of this subsection if sufficient funds were available for such purpose, the Administrator, based on criteria which the Administrator shall prescribe in regulations, shall assign a priority to each such grant application and shall approve grants in accordance with such priority.

"(B) The criteria required to be prescribed by subparagraph (A) of this paragraph shall take into account, among other factors, the demand on the Veterans' Administration for nursing home care and domiciliary care, as appropriate, for veterans eligible for such care in the geographic areas concerned and the extent to which it is feasible and desirable to meet such demand through the exercise of the authorities provided in sections 610 (a) and (b) and 620 (a) and (d) of this title to furnish nursing home care and domiciliary care through Veterans' Administration facilities and, in specified circumstances, other non-State home facilities.".

REPORT ON ALTERNATIVES FOR FEDERAL GOVERNMENT ASSISTANCE TO INDIVIDUALS WHO SERVED IN VIETNAM AS CIVILIANS

SEC. 9. (a)(1) The purpose of this section is to provide a basis for the executive branch and the Congress to evaluate alternative approach for providing individuals who served for a period of at least thirty days in the Republic of Vietnam during the Vietnam era as employees of—

(A) the United States Government, or

(B) organizations determined by the Administrator of Veterans' Affairs, in consultation with the Secretary of Defense, to be organizations which provided significant assistance to the United States Armed Forces in the Republic of Vietnam during the Vietnam era,

with Federal benefits and services (including, but not limited to, health care and monetary compensation for disabilities which may be related to exposure to dioxin or be the result of traumatic events), either through the Veterans' Administration or otherwise, and for assisting such individuals in connection with disabilities they may have incurred as a result of such service.

(2) In order to carry out the purpose stated in paragraph (1), the Administrator, the Secretary of Defense, and the Secretary of Health and Human Services, not later than one hundred and eighty days after the date of enactment of this Act, shall submit to the appropriate committees of the Congress a joint report setting forth various alternative approaches (together with comments on the appropriateness and the advantages and disadvantages of each), and any recommendations by such officials for legislative and administrative action with respect thereto, for establishing a program for providing such benefits, services, and assistance to such individuals.

(b) For the purposes of this section, the terms "Armed Forces" and "Vietnam era" have the meanings given such terms in section 101 (10) and (29), respectively, of title 38, United States Code.

[From the Congressional Record, Vol. 130, No. 12, pp. S1084-S1089--Senate, February 7, 1984]

VETERANS' ADMINISTRATION HEALTH-CARE PROGRAM IMPROVEMENTS ACT OF 1984

Mr. CRANSTON. Mr. President, as the ranking minority member of the Committee on Veterans' Affairs, I am today introducing for myself and Senators RANDOLPH, MATSUNAGA, and DECONCINI:

S. 2269, the proposed Veterans' Administration Health-Care Program Improvements Act of 1984. This measure addresses a variety of issues relating primarily to Veterans' Administration health-care services. Its basic underlying purpose is the continued imprrovement of the VA's ability to meet the needs of our Nation's veterans and their dependents. The VA, as the principal Federal agency with responsibility for providing for our veterans and their survivors, must be given the legislative authorities it needs in these rapidly changing times in order to carry out its mission fully and effectively. Our bill is directed toward that end.

SUMMARY OF PROVISIONS

Mr. President, the eight substantive provisions of our bill would:

First, expand the definition of the Vietnam era for the purposes of title 38, United States Code, so as to include service in Vietnam at any time during the period beginning on July 8, 1959 and ending on August 4, 1964, the day before the starting date of the Vietnam era in current law.

Second, in cases in which a veteran's family members have been receiving counseling or mental health services from the VA in connection with the veteran's care or counseling, authorize the VA to continue to provide services to those family members for a period of up to 6 months following the veteran's death.

Third, provide persons still on active duty in the Armed Forces who served during the Vietnam era with eligibility for VA readjustment counseling and authorize the Administrator of Veterans' Affairs to provide such eligibility to persons who served in the Armed Forces after the Vietnam era in combat-like situations.

Fourth, make permanent the VA's current, pilot-program authority to place veterans with alcohol or drug abuse dependencies or disabilities in non-VA halfway houses and other community-based programs for treatment and rehabilitation.

Fifth, provide the Administrator with new authority to increase rates of pay, for recruitment and retention purposes, for protective services employees at VA health-care facilities.

Sixth, modify the due date of a recurring Comptroller General's report on the Director of the Office of Management and Budget's compliance with certain statutory requirements relating to funded personnel ceilings for the VA's Department of Medicine and Surgery.

Seventh, require the Administrator to develop criteria pursuant to which applications for grants for the construction, remodeling, expansion, or alteration of State veterans' home facilities can be awarded on a basis other than first-come, first-served.

Eighth, direct the Administrator and the Secretaries of Defense and of Health and Human Services to submit to the Congress a joint report setting forth and evaluating various alternative approaches pursuant to which the Federal Government might provide benefits, services, and assistance relating to disabilities that possibly result from certain aspects of service in Vietnam—such as exposure to agent orange or to particularly traumatic events—in individuals who were present there during the Vietnam era as civilian employees of the Federal Government or of organizations that provided significant assistance to U.S. forces, such as the American Red Cross or the USO.

VIETNAM-ERA VETERANS READJUSTMENT COUNSELING PROGRAM

Mr. President, the VA's program for providing readjustment counseling to Vietnam-era veterans, which was initially authorized in 1979, continues to be the most important and effective Government program for assisting those Vietnam-era veterans who have experienced readjustment difficulties since their service. Although there are some problems in the operation of the program—most notably in the fee-for-service portion—I am satisfied that this program, now operating out of 135 Vet centers, is very successful. Last year, in Public Law 98-160, the program as it is presently constituted was given a 4-year extension, until September 30, 1988. This extension should provide sufficient long-term stability for the program to permit appropriate management improvements to be made. With reference to the fee-for-service portion of the program, I ask unanimous consent that a recent exchange of letters that I had with the VA—my December 9, 1983, letter to the VA's Chief Medical Director, Dr. Donald Custis, and Dr. Custis' January 30, 1984, letter in response—be printed in the RECORD at this point.

There being no objection, the letters were ordered to be printed in the RECORD, as follows:

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C., December 9, 1983.

Dr. DONALD L. CUSTIS,
Chief Medical Director, Veterans' Administration, Washington, D.C.

DEAR DON, as you know, I have had an ongoing interest in the status of the contract between the Veterans' Administration and Swords to Plowshares for the provision of readjustment counseling. In this connection, I recently had the opportunity to review the October 28, 1983, opinion of the General Counsel regarding the payment of certain sums under that contract. That opinion includes the following statement:

> [W]e hope that the confusion and difficulty encountered in connection with the administration of this contract will demonstrate the need for a complete review and evaluation of all contracts now outstanding to provide readjustment counseling, as well as a new awareness within the VA of the need for improved contract management and oversight.

I agree wholeheartedly about the need for a "complete review and evaluation of all contracts" and for "improved contract management and oversight", and urge your prompt consideration of these actions.

In view of the problems that have come to light regarding the administration of these contracts, I believe it is vitally important at this time that all existing contracts be reviewed to determine which services are being provided and to which veterans. It is even more important that the agency, as soon as possible, decide how best to monitor the fee/contract program in the future and then commit the resources necessary—including the personnel needed—to carry out that task.

As successful as the readjustment counseling program has generally been through the Vet Centers in helping a great many Vietnam-era veterans and their families deal more effectively with post-war readjustment difficulties, questions about the fee-basis portion of the program have persisted from that program's inception. They have now reached a point where, unless satisfactorily resolved, they threaten to undermine the reputation and support for the entire program.

In a May 17, 1983, letter to me, you stated that "the Readjustment Counseling Service is addressing itself to developing a mechanism for monitoring the [fee/contract] program as to consistency, quality, and cost-effectiveness." The current controversy surrounding the Swords to Plowshares contract and numerous reports of similar situations involving other contracts as to which inadequate monitoring of contractors is also alleged would seem to be compelling evidence that the efforts described as being underway eighteen months ago have yet to be successful.

In carrying out the review and evaluation called for by the General Counsel, I believe that the agency should, at a minimum, address the following questions:

(1) A. Should the monitoring of contracts for readjustment counseling remain with the Readjustment Counseling Service or should some other office in the agency (e.g., the Office of Procurement and Supply) be given this responsibility?

B. If the actual monitoring function is shifted, should the Readjustment Counseling Service remain responsible for providing technical assistance (i.e., orientation, education, and training assistance) to contractors?

(2) In view of the answers to question 1, how many additional FTEE are needed for contract monitoring and how many for technical assistance purposes and where should the personnel be located?

(3) What should the general qualifications be for individuals in such positions and should they have prior experience with the Vet Center program?

With respect to question 1, I believe there is very strong reason for retaining this responsibility in the Readjustment Counseling Service field locations where the actual counseling experience and the knowledge of local veterans and conditions is so abundant. Also, the very great need for the performance of this technical assistance function for many contractors without extensive Vietnam veteran readjustment counseling experience raises two related questions: Whether the amount of technical assistance required suggests that too many resources are currently being allocated to contract services? Would not it enhance the program if some of these resources were used to expand in-house efforts over which the agency can exercise greater quality control?

With respect to question 2 regarding the number of FTEE needed, I note that, when the responsibility was initially given to the Readjustment Counseling Service to monitor contractors and to provide technical assistance, no additional personnel were assigned to the Vet Center program to carry out these new tasks. This created many diffisions around the country in which Vet Center personnel were forced, to the detriment of the overall program, to choose between carrying out the new responsibilities and fulfilling their other duties. For example, I have been advised that the Seattle, Washington, Vet Center team leader, in addition to his team leader responsibilities, was assigned monitoring and technical assistance responsibilities with respect to contractors who are located over a wide geographic area and to whom the VA might pay out over $300,000 in one year for counseling services. Plainly, it is not possible for one person to carry out effectively such multiple responsibilities.

Thus, if the agency should decide that either the monitoring or the technical assistance responsibility, or both, should remain with the Vet Center program, I believe that it is vital that additional personnel be assigned for such purpose or purposes. (One suggestion that might be considered in the event of such a decision would be to employ former Vet Center personnel—particularly those who have been involved in direct counseling but who need some relief from the stress of that role—to work with fee/contract providers.)

On a related matter, you will recall that we exchanged a number of letters last year and earlier this year that addressed, among other issues, the agency's proposal for using fiscal year 1983 readjustment counseling moneys for fee-basis contracts. In that correspondence and in other ways, I repeatedly urged that steps be taken to avoid spending for non-readjustment counseling purposes any of the funds that the agency had identified as intended but which were not needed for the fee/contract program. I deeply regret that this result was not avoided; indeed, it is doubly regrettable that the purposes of these expenditures bears no direct relationship whatsoever to Vietnam-era veterans.

As I did last year, I strongly urge that the agency estimate—as soon as possible—the approximate amount that will be expended in the current fiscal year on the fee/contract portion of the program. To the extent that that amount is less than the $11 million that the agency has noted, in response to questions following our Committee's February 16, 1983, hearing on the FY 1984 budget, were to be devoted to such purposes, the agency should promptly determine and thereafter advise the Appropriations and Veterans' Affairs Committees in both Houses how it proposes to utilize the balance of these earmarked funds. I very much hope you will move forward on this suggestion immediately.

Don, I deeply appreciate your continuing cooperation and assistance and your attention to this particular matter. I look forward to receiving your response to this letter as soon as possible, and would greatly appreciate your addressing specifically each of the points discussed above.

With warm regards,
Cordially,

ALAN CRANSTON,
Ranking Minority Member.

VETERANS ADMINISTRATION,
DEPARTMENT OF MEDICINE AND
SURGERY,
Washington, D.C., January 26, 1984.
Hon. ALAN CRANSTON,
Ranking Minority Member, Committee on Veterans' Affairs, United States Senate, Washington, D.C.

DEAR SENATOR CRANSTON: Thank you for your letter of December 9, 1983 concerning the readjustment counseling program and the management of the fee/contract program.

OMB Circular 10-83-100, A-123 Internal Control Systems, identifies certain areas as being highly vulnerable to fraud, waste, and abuse. While the readjustment counseling program, we are concerned about the performance of contractors providing counseling services. An internal control review of the fees/contract program was originally scheduled to be conducted in May 1984. We decided to accelerate that timetable. A task force was formed in mid-October to examine various aspects of the contracts program in accordance with the guidelines set forth in the circular cited above. This task force is chaired by Mr. Albert D. Washko, Director of the Albany, New York, VA Medical Center, and is working closely with the Office of Procurement and Supply, Medical Administration Service and Readjustment Counseling Service in Central Office. Their goal is to identify potential problems involving the fees/contract program at the field and VA Central Office levels; developing a format for review of internal controls; and making recommendations to improve the management and monitoring of this $11.2 million program.

Immediately following the completion of the first quarter, we shall be reviewing our current obligations for the fees/contract program and making an estimate for total fiscal year 1984 expenditures. I shall provide this figure to you once it is available.

In addition, we are now studying the possibility of contracting out for some monitoring of the contracts program. I shall be pleased to keep you informed of our initiatives in that area.

Your suggestions and concerns for the readjustment counseling program are appreciated.

Sincerely,

DONALD L. CUSTIS, M.D.,
Chief Medical Director.

Mr. CRANSTON. Mr. President, under current law, section 612A of title 38, eligibility for readjustment counseling services is limited to veterans of the Vietnam era and in certain circumstances, their family members.

The measure we are introducing today would make four changes in the law to expand the list of those eligible for such services.

First, individuals who served during the Vietnam era but who are still on active duty—and thus not veterans under the applicable title 38, United States Code, definition—would be made eligible for readjustment counseling. Although I am aware of no data suggesting an unmet counseling need among large numbers of active-duty personnel, I have heard from a number of individuals working in the program about requests for help from active-duty personnel. In any event, I do not believe that any individual who served in the Armed Forces during the Vietnam era and feels a need for readjustment counseling should be barred from eligibility simply because he or she is still on active duty. Section 4 of the bill would remove that bar.

Second, by virtue of an amendment to the definition of "Vietnam-era" in section 101(29) of title 38, United States Code, our bill would provide eligibility to certain veterans who served in Vietnam before the beginning of the Vietnam era. Under current law, the Vietnam era is defined as the period beginning on August 5, 1964, and ending on May 7, 1975. The starting date coincides with the Gulf of Tonkin resolution, which was unquestionably a watershed event in the history of U.S. involvement in Vietnam. However, there were many U.S. troops in Vietnam prior to that date and, as shown by the Vietnam Veterans Memorial on the Mall here in Washington, D.C.—on which the first persons listed died from hostile fire in 1959—these service personnel were under combat conditions well prior to 1964.

Mr. President, there are a number of practical difficulties in setting fixed dates for a period of hostilities, such as the Vietnam era, and I note that there were a variety of responses to this proposal to modify the starting date of the Vietnam era when it was before the committee in S. 11 last year. Nevertheless, I do not believe that it is appropriate to continue to tell those individuals who were exposed to armed hostilities in Vietnam prior to August 1964 that they are not veterans of a period of war. Thus, section 2 of the bill would amend title 38 to provide that for those veterans who served in Vietnam, the Vietnam era begins on July 8, 1959—the date the first U.S. military personnel were killed by enemy action in Vietnam. In addition to providing eligibility for readjustment counseling to those who served in Vietnam between that date and August 5, 1964, this change would provide them with general eligibility for certain other needs-based VA benefits, as well as employment assistance.

Mr. President, in selecting the date of July 8, 1959, as the beginning date for the Vietnam era, I note that I am aware of other dates that could be used. For example, the Veterans of Foreign Wars, in testimony last year on S. 11, suggested the date of July 1, 1958, the beginning date for award of the Armed Forces Expeditionary Medal for service in Vietnam. Also, section 1440 of title 8, United States Code, relating to the naturalization of aliens through active-duty service during periods of military hostilities, uses February 28, 1961, as the beginning of hostilities in Vietnam. Third, the Congressional Charter of the American Legion, which is set forth in section 45 of title 36, United States Code, uses the date of December 22, 1961, the date of the first direct combat-related death of a member of the Military Advisory Command Vietnam, to begin the Vietnam era. Cogent arguments can be made for any of these dates or others, and I hope that the committee will pursue this issue further this year.

Third, section 4 of the bill would provide for expanding the period of service that makes an individual eligible for readjustment counseling to include certain service after May 7, 1975, the end of the Vietnam era. Thus, the Administrator would be authorized to specify service during periods of time and in specific locations in which U.S. Armed Forces were under hostile fire as qualifying service for readjustment counseling purposes. This provision recognizes that members of our Armed Forces are at times exposed to situations short of declared war—such as exist in Beirut at present or on Grenada during the invasion of that island last year—that might produce the need for readjustment counseling after their service. I want to stress my view that this authority, if enacted, should be used by the Administrator, after consultation with the Secretary of Defense, only in very limited circumstances in which our service personnel actually experience combatlike situations.

Mr. President, a final provision in the measure in section 3 relates to eligibility for readjustment counseling assistance. Under current law, the VA may provide mental health counseling and certain other services to the family members of a veteran when doing so is necessary for the effective treatment of the veteran. This authority is available in the readjustment counseling program for the provision of services to the family of a veteran who is receiving readjustment counseling. All indications that I have received regarding the use of this family counseling authority in conjunction with readjustment counseling are that it has been of great importance in the agency's efforts to assist Vietnam-era veterans in need of readjustment assistance. Recently, however, I have become aware of situations in which veterans who were receiving readjustment counseling from the VA together with their family members have died—some, tragically, by suicide—leaving family members in perhaps greater need of assistance at the very time that, because of the veteran's death, they lost their eligibility for such assistance.

Moreover, receiving bereavement counseling from someone with whom the family member has already developed a supportive relationship will often be the most valuable way for that dependent to receive such counseling. We are proposing to amend current law so as to authorize the VA to continue, for up to 6 months following the veteran's death, to furnish appropriate mental health assistance to family members who were receiving it before the death of the veteran.

COUNSELING TO FAMILIES IN CONNECTION WITH HOSPICE AND OTHER CARE ARRANGEMENTS

Mr. President, the change I have just described would be made to section 601 (6) of title 38, which provides the general authority, under specified, limited circumstances, for counseling, mental health, and other services for a veteran's family members. Thus, the bill would authorize the continuation of services to the veteran's family in situations other than the readjustment counseling program in which family members are receiving services in connection with a veteran's care. One such area where this new eligibility could be of particular use would be in cases in which the VA is providing health care to an eligible veteran suffering from a terminal disease, such as in 1 of the VA's 16 experimental hospice programs. An appropriate, integral part of a program of hospice care is counseling for family members after the patient's death, and enactment of this provision would provide a clear statutory basis for the VA's furnishing care.

STUDY OF CIVILIANS WHO SERVED IN VIETNAM

Mr. President, in addition to the provisions that I have just outlined, which bear a relationship to veterans who served in the Vietnam conflict, a provision in the measure we are introducing is related to those individuals who served in Vietnam as civilians, either as Government employees or as employees of organizations that provided significant assistance to our Armed Forces. Major examples are the American Red Cross and the USO.

Under this provision, section 9 of the bill, the VA Administrator, in conjunction with the Secretaries of Defense and Health and Human Services, would be required, within 180 days after the date of enactment of this measure, to submit a report to the Congress advising on how the Federal Government might respond to the needs of those individuals for problems related to their work in Vietnam, such as for health problems that might be related to their exposure to dioxin from agent orange or to particularly stressful combat situations.

Mr. President, I am concerned that there may be significant numbers of individuals who made important contributions to the U.S. effort in Vietnam but who, because of their nonmilitary or non-Federal status during that period, may not now have access to adequate assistance—or access to any assistance at all—from the Federal Government for problems that might be related to their work in Vietnam. I believe that, particularly in those cases in which the Federal Government may be responsible for their condition, there is an obligation on the Government to provide appropriate redress. The report that would be mandated by this provision would be an important step toward providing some guidance on how to resolve this matter.

CONTRACT PROGRAM FOR DRUG/ALCOHOL TREATMENT

Mr. President, section 5 of the bill would amend section 620A of title 38, which provides authority pursuant to which the VA may contract with various community facilities to provide care and treatment to veterans suffering from alcohol or drug dependence or abuse disabilities, to change that authority from a pilot program to a permanent authority.

The pilot program authority—which I authored—was enacted in 1979 in Public Law 96-22 and is scheduled to expire on September 30, 1985. Pursuant to section 620A(f) of title 38, the Administrator is required to submit a report by March 31 of this year on the operations of the pilot program through September 30, 1983. I am looking forward to that report and expect that the results of that report will play an important role as the committee considers this legislation to make the pilot program authority permanent.

Although the VA's formal report on this program is not yet due and therefore no systematic evaluation of the program is yet available all of the evidence that I have reviewed—including reactions from veterans who have been placed in halfway houses and other community-based facilities, VA employees who work with veterans with drug or alcohol abuse dependencies, and individuals associated with various community-based drug and alcohol treatment programs—indicates that the pilot program has been quite successful in enabling significant numbers of veterans to receive appropriate and helpful assistance.

PROTECTIVE SERVICES PERSONNEL

Mr. President, in recent years, the VA has experienced significant difficulties in attracting and retaining security personnel at numerous health-care facilities around the country. This problem, which has been particularly acute at some of the larger VA medical centers located in urban areas, has had a detrimental impact on the level of security at many VA facilities and has also affected the morale of the security personnel. Although many factors have been suggested as causes of this problem, the point raised most frequently involves the level of pay available for such personnel. The common complaint that is voiced is that many individuals will work as VA security personnel only long enough to gain sufficient experience to enable them to be hired elsewhere in police or security jobs for higher pay.

In an effort to address this problem section 4 of the bill we are introducing today would give the Administrator of Veterans' Affairs new authority to increase rates of pay—including minimum, intermediate, or maximum rates—for protective services personnel and to do so on a nationwide, local, or other geographic basis as appropriate. Having this authority, which would be subject to Presidential disapproval for 90 days before any such increased rate could go into effect, would provide the VA with an important new tool with which to address these difficult recruitment and retention problems. Thus, for recruitment and retention purposes, this provision would treat security personnel the same as certain VA direct health-care personnel.

GRANTS FOR CONSTRUCTION OF STATE HOME FACILITIES

Mr. President, under title 38, the VA participates in two separate programs of assistance to State veterans' homes—one, a program of per diem payments to the homes for care provided to eligible veterans and, the other, a program of matching grants to the States for the construction, remodeling, or renovation of State veterans' homes.

The State home program is a vital adjunct to the VA's overall efforts, both now and in the coming years and decades, to meet the health-care needs of older veterans, and I strongly support the overall program. During the first session of this Congress, I was pleased to introduce legislation—S. 629 which was cosponsored by my colleagues on the committee, Senators RANDOLPH and SPECTER—that was ultimately enacted with modifications in section 105 of Public Law 98-160. This program provided for substantial increases in the State home per diem rates.

In this session, I am pleased to note that the VA, as part of the agency's fiscal year 1985 budget submission, is requesting a significant increase over the fiscal year 1984 appropriations level—from $15 million to $34.3 million—for the construction grant program. Although I have some questions about a few of the details of the agency's plans for spending those funds, I anticipate being able to support this request fully.

To improve the effectiveness of this

matching fund program, a provision in our bill would make a technical amendment to section 5035 of title 38. It is the VA's view that, under current law, the funding of otherwise qualifying grant applications must be provided on a *first-come, first-served* basis. A policy or practice of funding all qualifying applications in the order in which they were received does provide assurance that there will be no undue favoritism in choosing among such applications. However, unwavering adherence to that one principle makes it impossible to take into account substantive factors relating to the increased effectiveness of the program.

Although I am not convinced that the law requires such grant applications to be funded in the order received, I am satisfied that the VA does not intend to change this practice without legislation expressly authorizing it to do so. Because the dollar value of qualified grant applications already submitted to the VA exceeds the funds now available to it and requested for fiscal year 1985 and because the agency should be able to integrate its funding decisions in this program with other decisions regarding utilization of resources to meet the current and projected demand for nursing home and domiciliary care, I believe current law should be amended to give the VA flexibility in choosing among qualified grants. Thus, section 6 of the bill would amend section 5035 of title 38 to require the Administrator to issue regulations setting forth criteria by which grant applications would be rated and, then, in any year in which the value of approvable grants exceeds the funds appropriated for such purposes, to award such grants in accordance with the priority assigned. The priority would be required to take into account, among other things, the demand on the VA for nursing home and domiciliary care—the types of care which State homes are particularly well equipped to provide—in the geographic area concerned and the extent to which it is feasible and desirable to meet that demand through various VA authorities.

CONCLUSION

Mr. President, as I noted at the outset, the diverse provisions of this bill have as a general unifying purpose bringing about the continued improvement of the Veterans' Administration's ability to meet the needs of our Nation's veterans and their dependents. I look forward to working on this measure with the committee chairman, my good friend from Wyoming (Mr. SIMPSON), the cosponsors of the bill, and other members of the committee, the VA, the veterans' service organizations, and others interested in legislation affecting veterans.

Mr. President, I ask unanimous consent that the text of S. 2269 be printed in the RECORD at this point.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

* * * * *

[From the Congressional Record, Vol. 130, No. 37, pp. S3248-S3252--Senate, March 27, 1984]

VETERANS' ADMINISTRATION HEALTH-CARE PROGRAM IMPROVEMENT ACT OF 1984

CRANSTON AND MATSUNAGA AMENDMENT NO. 2850

(Referred to the Committee on Veterans' Affairs.)

Mr. CRANSTON (for himself and Mr. MATSUNAGA) submitted an amendment intended to be proposed to the bill S. 2269 to amend title 38, United States Code, to improve various aspects of Veterans' Administration health-care programs and to provide eligibility to new categories of persons for readjustment counseling from the Veterans' Administration; and to require the Administrator of Veterans' Affairs and the Secretaries of Defense and of Health and Human Services to submit a report on alternatives for providing Federal benefits and services to individuals who, as civilians, provided services to U.S. Armed Forces in Vietnam during the Vietnam era; and for other purposes, as follows:

(1) On Page 5, strike out line 23 and insert in lieu thereof the following:

Sec. 6. (a) Section 218 is amended to read as follows:

"§ 218. Security and law enforcement on property under the jurisdiction of the Veterans' Administration

"(a)(1) The Administrator, with the concurrence of the Attorney General, shall prescribe regulations to provide for the maintenance of law and order and the protection of persons and property on land and in buildings under the jurisdiction of the Veterans' Administration and not under the control of the Administrator of General Services (hereinafter in this section referred to as 'Veterans' Administration property'). Such regulations shall prescribe, but need not be limited to—

"(A) the penalties, within the limits specified in paragraph (2) of this subsection, for violations of laws and regulations on Veterans' Administration property,

"(B) the authority, consistent with the provisions set forth in subsection (b) of this section, of Veterans' Administration protective services officers to enforce laws and regulations and to make arrests,

"(C) the scope and duration of training that is required for Veterans' Administration protective services officers, with particular emphasis on dealing with situations involving patients, and

"(D) rules limiting the carrying and use of weapons by Veterans' Administration protective services officers.

Laws and regulations (including penalties for violations thereof prescribed under this paragraph) shall be posted conspicuously on such property.

"(2) Whoever violates any regulation prescribed under paragraph (1) of this subsection shall be fined not more than $500 or imprisoned not more than six months (or such lesser amount or period of time as the Administrator prescribes in such regulations), or both.

"(b) The Administrator may designate employees of the Veterans' Administration protective services officers. Such officers shall enforce Federal laws, and the regulations prescribed under subsection (a) of this section, on Veterans' Administration property. Any Veterans' Administration protective services officer may make an arrest, with or without a warrant, for any offense on Veterans' Administration property if (1) such offense occurs in such officer's presence, or (2) such officer has reasonable grounds to believe (A) that the offense constitutes a violation of any law of the United States or of any regulation prescribed under subsection (a) of this section, and (B) that the person to be arrested has committed that offense.

"(C) With the agreement of the head of the agency concerned, the Administrator may use the facilities and services of Federal, State, and local law enforcement agencies when it is economical and in the public interest to do so.

"(d)(1) Notwithstanding subchapter I of chapter 59 of title 5, the Administrator, pursuant to regulations which the Administrator shall prescribe, may pay allowances within the limits of paragraph (2) of this subsection, for the purchase of such uniforms, to any Veterans' Administration protective services officer who is required to wear a prescribed uniform in the performance of official duties.

"(2) Allowances that the Administrator may pay under paragraph (1) of this subsection for the purchase of uniforms shall not exceed—

"(A) at the time the individual is first employed as a Veterans' Administration protective services officer, $400; and

"(B) at the beginning of the first fiscal year that begins after the individual has completed twelve months of service as a Veterans' Administration protective services officer and at the beginning of each subsequent fiscal year, $200."

(b) The item relating to such section in the table of sections at the beginning of chapter 3 of such title is amended to read as follows:

"218. Security and law enforcement on property under the jurisdiction of the Veterans' Administration.".

(c) Section 4107(g) is amended—

(2) At the end of the bill, add the following new sections:

CONTRACT CARE IN PUERTO RICO AND THE VIRGIN ISLANDS

Sec. 10. Section 601(4)(C)(v) is amended by striking out "September 30, 1984," and inserting in lieu thereof "September 30, 1985,".

PAYMENT FOR THERAPEUTIC AND REHABILITATION ACTIVITIES

Sec. 11. Section 618 is amended by adding at the end the following new subsection:

"(f) Notwithstanding any other provision of law, no amount of remuneration provided to an individual as a participant in a therapeutic or rehabilitative activity carried out pursuant to this section shall be included in determining annual income for purposes of pension payments.".

POST-TRAUMATIC-STRESS DISORDER TREATMENT

Sec. 12. (a) In order to enhance the Veterans' Administration's capability to diagnose and treat post-traumatic stress disorder (hereinafter in this section referred to as "PTSD"), the Administrator of Veterans' Affairs shall establish a national center on PTSD (1) to carry out and promote research into, and the training of health-care personnel in, the diagnosis and treatment of PTSD, and (2) to serve as a resource center for and to promote and to seek to coordinate the exchange of information regarding all research and training activities carried out by the Veterans' Administration, and by other Federal and non-Federal entities, with respect to PTSD.

(b) Not later than 90 days after the date of the enactment of this Act, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report containing a description of the steps taken and plans made (and a timetable for their execution) to establish such a center. The report shall also contain (1) the assessment of the Chief Medical Director of the Veterans' Administration regarding the capability of the Veterans' Administration to provide inpatient and outpatient PTSD diagnosis and treatment (both through PTSD inpatient treatment units and otherwise) as well as a description of the results of any evaluations that have been made of PTSD inpatient treatment units in existence on the date of the enactment of this Act, (2) any recommendations and a description of any activities planned for improving such diagnosis and treatment and for correcting any deficiencies in the operations of such units, and (3) the Administrator's assessment of the capacity of the Veterans' Administration to meet the need for PTSD diagnosis and treatment in all geographic areas of the United States and any plans and timetable for increasing that capacity (including the costs of such actions).

AMENDMENT NO. 2850: VETERANS' ADMINISTRATION HEALTH-CARE SYSTEM IMPROVEMENTS

Mr. CRANSTON. Mr. President, I am today introducing, on behalf of myself and Senator MATSUNAGA, amendment No. 2850, an amendment to S. 2269, the proposed Veterans' Administration Health-Care Program Improvements Act of 1984. S. 2269 is presently pending in the Veterans' Affairs Committee and is to be considered during a committee hearing scheduled for April 11. It is our expectation, in introducing this amendment today, that the various provisions included in it will also be addressed at that hearing.

Mr. President, as I noted in my remarks in introducing S. 2269—which begin on page S1084 of the daily edition of the RECORD for February 7, 1984—that legislation has as its basic underlying purpose the continued improvement of the VA's ability to meet the needs of our Nation's veterans and their dependents. The various provisions in the amendment we are introducing today have the same purpose.

SUMMARY OF PROVISIONS OF S. 2269

Mr. President, as I noted when I introduced S. 2269 on February 7, the eight substantive provisions of that bill would:

First, expand the definition of the Vietnam era for the purposes of title 38, United States Code, so as to include, in the case of veterans who served in Vietnam at that time, the period beginning on July 8, 1959, through August 5, 1964, the starting date of the Vietnam era in current law.

Second, in cases in which a veteran's family members have been receiving counseling or mental health services from the VA in connection with the veteran's care, authorize the VA to continue to provide services to those family members for a period of up to 3 months following the veteran's death.

Third, provide persons still on active duty in the Armed Forces who served during the Vietnam era with eligibility for VA readjustment counseling and authorize the Administrator of Veterans' Affairs to provide such eligibility to persons who served in the Armed Forces after the Vietnam era in combat-like situations.

Fourth, make permanent the VA's current, pilot-program authority to place veterans with alcohol or drug abuse dependencies or disabilities in non-VA halfway houses and other community-based programs for treatment and rehabilitation.

Fifth, provide the Administrator with new authority to increase rates of pay, for recruitment and retention purposes, for protective services employees at VA health-care facilities.

Sixth, modify the due date of a recurring Comptroller General's report on the Director of the Office of Management and Budget's compliance with certain statutory requirements relating to funded personnel ceilings for the VA's Department of Medicine and Surgery.

Seventh, require the Administrator to develop criteria pursuant to which applications for grants for the construction, remodeling, expansion or alteration of State veterans' home facilities can be awarded on a basis other than first-come, first-served.

Eighth, direct the Administrator and the Secretaries of Defense and of Health and Human Services to submit to the Congress a joint report setting forth and evaluating various alternative approaches pursuant to which the Federal Government might provide benefits, services, and assistance relating to disabilities that possible result from service in Vietnam—such as exposure to agent orange or to particularly traumatic events—to individuals who were present there during the Vietnam era as civilian employees of the Federal Government or of organizations that provided significant assistance to U.S. forces, such as the American Red Cross and the USO.

SUMMARY OF PROVISIONS OF AMENDMENT

Mr. President, the provisions of the amendment we are introducing today would:

First, improve and clarify the Administrator of Veterans' Affairs authority to provide security on VA property through a force of VA protective services officers and authorize a special uniform allowance for them.

Second, provide a 1-year extension, until September 30, 1985, in the VA's authority to provide certain fee-basis health care to veterans in Puerto Rico and the Virgin Islands.

Third, specify that any remuneration received by VA patients in a rehabilitation therapy program under section 618 of title 38, United States Code, shall not be counted as income for the purpose of VA pension programs.

Fourth, mandate that the VA establish a national center for research into post-traumatic stress disorder—PTSD—and for training VA health-care personnel on appropriate treatment for veterans with this disorder, and require the VA to assess and report on its ability and capability, including the capacity of its existing PTSD treatment units, to provide diagnosis and treatment to veterans with such disorder.

PROTECTIVE SERVICES EMPLOYEES

Mr. President, section 4 of S. 2280 as introduced, in order to improve the VA's ability to attract and retain protective services personnel, would give the Administrator new authority to increase rates of pay for such personnel.

After I introduced S. 2280, the House Committee on Veterans' Affairs Subcommittee on Health and Hospitals held a hearing on, among other matters, issues related to VA security. After reviewing the testimony of the VA and veterans service organizations at that hearing, it is apparent that, although pay flexibility is the most critical issue that needs to be addressed at this time, a variety of other concerns should also be considered by our committee at this time. To this end, the amendment we are introducing today would clarify the Administrator's authority to designate individuals to serve as VA protective services officers; would require the Administrator to issue regulations relating to such officers' authority to make arrests, the content and duration of such officers' training, and other law enforcement matters; and would authorize a special VA protective services officers' clothing allowance.

CONTRACT CARE IN PUERTO RICO AND THE VIRGIN ISLANDS

Mr. President, the question of how the VA should provide health care to eligible veterans in Puerto Rico and the Virgin Islands—both now and in the years ahead—is a longstanding one. Despite repeated requests to the VA from our committee and the House Veterans' Affairs Committee for a comprehensive plan to provide this care and, indeed, despite a statutory mandate—in section 107 of Public Law 98-160—that the VA develop and present such a plan, the agency has continued to refuse to come to grips with this issue in a manner that would provide a basis for congressional action.

Most recently, on February 16, 1984, the VA, in response to the most recent statutory mandate—in Public Law 98-160—presented the Congress with yet another incomplete report on this issue. As with prior submissions, the VA deferred any final decisions, this time indicating its most current review and analysis of this situation will be completed this spring as part of the fiscal year 1986 budget preparation.

In an attempt to gain better insight into this issue, both Veterans' Affairs Committees sent staff members to Puerto Rico in February. This visit yielded some important firsthand impressions which will help further inform the two committees about what steps to take once the VA finally comes forward with its comprehensive plan—including any recommendations for legislative action or construction authorization—later this year.

Unfortunately, because the VA did not produce such a plan at the beginning of this session of Congress as had been expected by the Congress, we must give serious consideration to yet another 1-year extension of the existing special authority pursuant to which the VA provides care for certain veterans in Puerto Rico and the Virgin Islands on a contract or fee basis. At present, that authority is scheduled to expire on September 30, 1984. Because we do not believe that the Congress will have sufficient time to evaluate the VA's plan and take appropriate action on it by that time, we are proposing a further 1-year extension—until September 30, 1985—of this authority.

STATUS OF PATIENTS/PARTICIPANTS IN INCENTIVE THERAPY

Mr. President, under section 618 of title 38, United States Code, the VA is authorized to conduct programs of rehabilitation and therapy under which participants—VA patients selected for such programs—perform services for which they receive a small payment. Known commonly as incentive therapy, the primary emphasis of these programs is on their therapeutic benefit and not on the relatively minor monetary benefit to the participants. Nevertheless, as the author of this authority in current law, I have always understood—and I believe it is generally agreed—that the payment aspect of the program is a vital component.

Over the past several weeks, I have received numerous inquiries—from staff of these incentive therapy programs, other VA employees, patients/participants in such programs, veterans service organizations, and others—about a recent change in the program. As the result of a direction from the Office of Managment and Budget, the VA has recently instituted a procedure whereby the payments veteran patients are receiving under incentive therapy programs are being counted as income to the veterans for the purpose of determining their entitlement to VA pension. For many of these veterans who are in receipt of pensions under the VA's current non-service-connected disability pension program, this change in how incentive therapy payments are counted has the result of reducing benefits by an amount equal to the amount received by the veteran under incentive therapy. Thus, for every dollar they received under incentive therapy, their pension is reduced by $1 and they are no better off financially as the result of their participation. This change in how these funds are counted has already had the entirely predictable result of discouraging participation in incentive therapy programs among those in receipt of VA pension.

In the cases of veterans/participants receiving "grandfathered" pension payments under section 306 of the Veterans' and Survivors Pension Improvement Act of 1978—veterans who were receiving pension on December 31, 1978, the day before the current program took effect and have not elected to receive pension under the current program—if their incentive therapy payments, when added to their other income, exceed the annual income limitation on which their continuing entitlement to section 306 pension is based, they are permanently dropped from the section 306 pension rolls.

Without at this point debating whether the OMB interpretation of existing law is correct, I am very concerned that this change in how incentive therapy payments are counted for pension program purposes has the very real potential to disrupt if not destroy many of these therapeutic programs and hence deprive many disabled veterans of the vital opportunities for enhanced functioning and self-esteem that are provided through their participation in the incentive therapy program. To avoid this result, the amendment we are introducing today would amend section 618 of title

38 to specify that payments to participants in programs carried out under that section are not to be counted as income for the purposes of VA pension.

POST-TRAUMATIC-STRESS DISORDER TREATMENT

Mr. President, although the VA had made some strides in the diagnosis and treatment of post-traumatic-stress disorder (PTSD) I am concerned that the agency could be doing much more in a coordinated fashion. The efforts to date—principally through the VA's 135 vet centers and the relative handful of PTSD inpatient treatment units of which there are 10 open at present—have lacked any apparent coherent design or overall plan.

PTSD is a disorder that is particularly prevalent among veterans—indeed, one of the stressors identified in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, third edition, as a cause of the disorder is combat—and apparently especially so among Vietnam combat veterans. Thus, I believe that the VA has a very strong obligation to be at the forefront of efforts to understand and treat PTSD.

For this reason, the committee has twice urged the VA in committee reports—Senate Report No. 97-89 accompanying S. 921 in the 97th Congress and Senate Report No. 98-145 accompanying S. 578 in this Congress—to consider seriously the establishment of a national center of excellence where research into diagnosing and treating PTSD could take place and also where training of health-care personnel on diagnosing and treating PTSD could go on. In addition to the committee's urgings, I have personally pursued, in letters to the VA's Chief Medical Director, the need to establish such a center as well as the need for greater geographic dispersal of inpatient treatment facilities. Unfortunately, the response to date to the committee's and my personal urgings, including the Chief Medical Director's most recent letter to me on this issue dated February 22, has not been particularly forthcoming.

Because of the importance of this issue regarding the VA's PTSD efforts, the amendment we are introducing includes a provision to mandate the Administrator to establish such a center and to report within 90 days after enactment of this act on the agency's efforts to carry out that mandate. In that report, the Administrator would also be required to provide an assessment of the agency's present capability to provide diagnosis and treatment to veterans suffering from PTSD—including discussing the results of agency evaluations of its PTSD treatment units—and any recommendations for changes in existing PTSD treatment programs, including providing greater geographic dispersion.

CONCLUSION

Mr. President, as I mentioned at the outset of my remarks, the legislation that I am proposing to amend—S. 2269—is scheduled for committee consideration at a hearing presently scheduled for April 11. I look forward to receiving and reviewing the comments of the VA, veterans service organizations, and others with an interest in this legislation on the provisions of the bill and of the amendment I am introducing today.

Mr. President, I ask unanimous consent that the text of correspondence I have had with the VA's Chief Medical Director on PTSD diagnosis and treatment be printed in the Record.

There being no objection, the material was ordered to be printed in the Record, as follows:

Committee on
Veteran's Affairs,
Washington, D.C., October 18, 1983.
Dr. Donald L. Custis,
Chief Medical Director, Veterans' Administration, Vermont Avenue NW., Washington, D.C.

Dear Don: Although I recognize that the VA has recently begun to play a leadership role in the diagnosis and treatment of post-traumatic stress disorders (PTSD) in Vietnam veterans, I am writing to urge further actions by the agency in this regard. Recent visits by Committee Minority staff members to VA facilities in Southern California and the State of Washington have convinced me that there is an important need for the Department of Medicine and Surgery (DM&S) to develop a strategy and plan for the treatment of PTSD throughout the system.

One of the most important elements that I believe should be addressed as part of any such overall approach is the establishment of additional in-patient programs for the treatment of PTSD—particularly the region west of the Mississippi where only 2 of the 10 in-patient PTSD units are located. I continue to receive from Vietnam veterans, their families, and others interested in the treatment of PTSD very strong, positive feedback about the 10 existing in-patient programs—especially the first of these programs, which is located at Menlo Park, California. At the same time, I continue to receive very strong indications about the need for more such programs, both to provide additional treatment capacity and to provide access to such programs on a wider geographic basis.

With respect to the recent staff visits referred to above, personnel at various Los Angeles area Vet Centers gave examples of clients whom they believed needed the type of assistance that could be provided only in such an in-patient program and how difficult it was to get such veterans admitted to the Menlo Park program, which does not have the resources to meet the demand. Likewise, in Washington State, much support was expressed for the establishment of such a program in that region. There seemed a general consensus that such a program could be best accommodated at the American Lake VAMC if additional FTEE were provided.

On this last point, the following statement by American Legion National Field Representative Rodney Kirk appeared in his recent visitation report on the American Lake VAMC:

"The Chief [of the Psychiatry Service] was informed of previous discussions held with personnel at the Vietnam Veterans Outreach Center, and their desire to implement a special unit for veterans with Post Traumatic Stress Disorders (PTSD). Although the Chief agrees with the need, it would be impossible to properly staff such a unit without additional resources."

Don, I would deeply appreciate it if, at your earliest convenience, you would provide me with your views on the need for and your intentions regarding a nationwide DM&S PTSD plan and additional inpatient PTSD units in the region west of the Mississippi, particularly in Southern California and the Seattle/Tacoma area. In addition, I would appreciate your thoughts on the recommendation that the Committee has made in two separate reports (S. Rept. No. 97-89 (p. 17) accompanying S. 921 in the 97th Congress and S. Rept. No. 98-145 (p. 33) accompanying S. 578 in the current Congress) that the VA establish a Center for Post Traumatic Stress Disorder. Such a center of excellence, together with a nationwide PTSD treatment strategy and a planned, coordinated expansion of in-patient programs, would, I believe, reinforce the VA's leadership role in the diagnosis and treatment of PTSD and be of major benefit to Vietnam veterans.

Thank you for your continued cooperation.

With warm regards,
Cordially,
Alan Cranston,
Ranking Minority Member.

Veterans' Administration,
Department of Medicine and
Surgery,
Washington, D.C., December 19, 1983.
Hon. Alan Cranston,
Ranking Minority Member, Committee on Veterans' Affairs, U.S. Senate, Washington, D.C.

Dear Senator Cranston: Thank you for your inquiry about the Veterans Administration's policy and nationwide plan for the treatment of Post-traumatic Stress Disorder (PTSD) and other inpatient treatment programs.

Historically, the existing programs have developed in large VA medical centers with active Psychiatric Services where there were sufficient psychiatric beds to enable available resources to be shifted, or consolidated, to allow the development of inpatient units for the treatment of Vietnam veteran patients. As you have mentioned, most of these programs are in the eastern part of the country.

The need for PTSD-oriented programs in our VA medical centers is being actively discussed by the Mental Health and Behavioral Sciences Service and the Readjustment Counseling Service. The basic problem is that Vietnam veterans are subject to many types of mental health disorders which do not necessarily lend themselves to treatment in the same unit. The appropriate mix of patients, the optimal length of stay, the balance of professional and nonprofessional personnel, and the necessary follow-up resources are all matters which require attention.

We are presently evaluating the need for such PTSD units and will attempt to develop guidelines which can be incorporated in our Medical District Initiated Program Planning (MEDIPP). When completed, this approach would give appropriate coverage to those areas west of the Mississippi, and would provide for PTSD-oriented activities and training. We agree with you on the importance of the diagnosis and treatment of PTSD as well as the other mental health problems being experienced by Vietnam veterans.

Sincerely,
Donald L. Custis, M.D.,
Chief Medical Director.

Committee on Veterans' Affairs,
Washington, D.C., December 28, 1983.
Dr. Donald L. Custis,
Chief Medical Director, Veterans' Administration, Vermont Avenue NW., Washington, D.C.

Dear Don: Thank you for your December 19, 1983, letter, signed by Dr. Gronvall in your absence, in response to my earlier letter regarding the Veterans' Administration's efforts in the diagnosis and treatment of post-traumatic stress disorders. (PTSD).

I am pleased that efforts are underway in DM&S to evaluate the need for additional in-patient programs to treat PTSD and that you agree with my view that the VA must play a leadership role in this area. So that I might better understand the status of your efforts, I would appreciate further information in this regard. Specifically, I am interested in answers to the following questions:

What office or official within the VA has been assigned the leadership role for the evaluation and other efforts described in your letter?

What specific efforts have been undertaken to date in this regard? Which are planned?

What guidance is presently available to field stations which might be interested in establishing an in-patient PTSD unit (please provide copies of any such guidance)?

What is the timetable for the development of formal PTSD-unit guidelines for incorporation into MEDIPP?

Finally, I would appreciate your thoughts on one point which I raised in my prior letter but which you did not address—namely, the establishment of a VA Center for Post-Traumatic Stress Disorder. I do not believe such an entity should be viewed as simply another PTSD unit. Rather, I believe that it would serve as a center of excellence where a mix of treatment, research, and education relating to PTSD would take place. I again urge that serious consideration should be given within the agency to the establishment of such a center, and I would appreciate knowing your thoughts on this proposal, which has been twice recommended in reports of the Senate Committee on Veterans' Affairs.

With warm regards,

Cordially,

ALAN CRANSTON,
Ranking Minority Member.

VETERANS ADMINISTRATION,
Washington, D.C., *February 22, 1984.*

Hon. ALAN CRANSTON,
Ranking Minority Member, Committee on Veterans' Affairs, U.S. Senate, Washing[illegible] *D.C.*

[illegible] CRANSTON: Thank you for your [illegible] requesting additional information concerning the Department of Medicine and Surgery's approach to the development of additional units for the treatment of Post-traumatic Stress Disorder.

Because inpatient treatment units for Vietnam veterans accept patients with a variety of conditions including post-traumatic stress disorder, depression, and other medical conditions, these units are assigned to the Psychiatry Services at each medical center where they are currently located.

Mental Health and Behavioral Sciences Service has the responsibility to provide planning and development assistance for these units. Dr. John O. Lipkin, Associate Director for Psychiatry, Mental Health and Behavioral Sciences Service has been active in providing assistance to VA medical centers interested in developing Vietnam veteran inpatient programs.

The most recent MEDIPP planning documents included requests for two PTSD inpatient units. The MEDIPP guidelines for planning include recommendations that each medical district without a Vietnam veteran unit consider its need for such a unit in the next submission to Central Office. Formal guidelines concerning the structure of these programs have not been published, because these units are still relatively new and undergoing constant evolution. There is less than unanimity among our psychiatric staff as to the desirability of these units. Centrally directed guidance at this point is, therefore, premature.

Discussions are underway concerning the development of a VA center for post-traumatic stress disorder. The availability of re[illegible] will be an important consideration in the development of this center.

Sincerely,

DONALD L. CUSTIS, M.D.,
Chief Medical Director.

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C., March 23, 1984.

Dr. DONALD L. CUSTIS,
Chief Medical Director, Veterans' Administration, Washington, D.C.

DEAR DON: Thank you for your February 22, 1984, letter, signed by Dr. Gronvall in your absence, in response to my earlier letter regarding the Veterans' Administration's efforts in the diagnosis and treatment of post-traumatic stress disorders (PTSD). I have a number of follow-up concerns and questions relating to this issue as to which I would appreciate your views and responses.

1. In your letter, you noted that "[t]here is less than unanimity among our psychiatric staff as to the desirability of these units."

A. What steps are you taking to resolve this lack of agreement?

B. In light of this lack of agreement, I was surprised to read the article "Wards Opened For Stress Patients" in the March 1984 VAnguard (copy enclosed) which gave no indication that there is any question within the VACO about the "desirability of [PTSD units]" and indeed noted that "additional wards [beyond the ten now open] are expected to open this year." I recognize that articles in VAnguard are not statements of official agency policy; nevertheless, I would appreciate your views on how the discrepancy on this issue between the VAnguard article and your recent letter can be reconciled.

C. It is noted in the VAnguard article that an eleventh PTSD inpatient unit "is expected to open sometime this year at Lyons, N.J." When was the decision made to open this unit and, to the extent it was under consideration at the time of your February 22 letter, why was it not mentioned in that letter?

2. I was pleased to note the statement in your February 22 letter that "[d]iscussions are underway concerning the development of a VA center for Post-traumatic Stress Disorder."

A. (i) Who is participating in these discussions and, specifically, have you solicited the views of any individuals from outside of the agency (such as those serving on the VA's Advisory Group on Readjustment Problems of Vietnam Veterans) who might be able to contribute to these discussions?

(ii) What is the timetable for the discussions and when do you anticipate being able to make a decision in this matter?

(iii) Is Dr. Arthur Blank participating? If not, why not, given his vast experience in treating PTSD and his perspectives as head of the Rehabilitation Counseling Service?

(iv) Similarly, is Dr. Blank a participant in DM&S decision-making regarding PTSD treatment, education, and research, and, if not, why not?

B. Which, if any, of the existing PTSD units (or other parts of the medical centers where the units are located) have expressed an interest in serving as such a center?

C. Your letter refers to the "availability of resources" as an important consideration in the development of such a center. What recurring and non-recurring resources—in terms of both FTEE (by type of position) and funds—would be required to establish and operate such a center for a 20-bed unit and, alternatively, for a 50-bed unit?

3. With further reference to the issue of the establishment of a national resource center, Senator Simpson, in a follow-up question (question 46) to the Committee's February 8 hearing on the agency's fiscal year 1985 budget, noted his understanding that the PTSD unit at the Topeka VAMC had been designated as a "national resource center for PTSD" and asked what additional funding has been provided to Topeka VAMC in support of this project. The agency's answer, without commenting on the status of this PTSD unit as a national resource center, noted that "[n]o additional funds have been directed to this Medical Center for this purpose."

A. Has the Topeka VAMC PTSD unit been designated as a national resource center for PTSD?

B. (i) (If yes) When did this occur and what are the implications of the designation for the Topeka unit and its relationships with other PTSD units throughout the VA?

(ii) (If not) Do you intend to so designate this or any other PTSD unit as a national resource center, and, if so, when do you anticipate making such a designation?

4. As you know, the Committee, in its recommendation to the Senate Budget Committee regarding the VA's fiscal year 1985 budget, recommended that an additional 180 FTEE and $5.5 million be provided to the agency "to improve the VA's ability to treat veterans suffering from post-traumatic stress disorder". This recommendation will also be made by Chairman Simpson and me to the Senate Appropriations Committee. If the Committee's recommendations in this regard are adopted in the appropriations process, how would you propose to use such resources and, specifically, to what extent would you provide support to existing centers and to what extent to the establishment of new centers?

Thank you, Don, for your continuing cooperation and assistance and for your attention to this letter.

With warm regards,

Cordially,

ALAN CRANSTON,
Ranking Minority Member.

II

98TH CONGRESS
2D SESSION

S. 2278

Entitled the "Care for Chemically Dependent Veterans Act".

IN THE SENATE OF THE UNITED STATES

FEBRUARY 8 (legislative day, FEBRUARY 6), 1984

Mr. BOSCHWITZ introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

Entitled the "Care for Chemically Dependent Veterans Act".

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That subsection (a)(1) of section 620A of title 38, United States Code, is amended to read as follows:

"(a)(1) The Administrator, in furnishing hospital, nursing home, and domiciliary care and medical and rehabilitative services under this chapter, may contract for care and treatment and rehabilitative services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities for eligible veterans suffering from alcohol or drug dependence or abuse disabilities.".

(2) Such section is further amended by striking out subsection (e) and redesignating subsections (f) and (g) as subsections (e) and (f), respectively.

(b)(1) The section heading of such section is amended by striking out "; **pilot program**".

(2) The item relating to section 620A in the table of sections at the beginning of chapter 17 of such title is amended by striking out "; pilot program." and inserting in lieu thereof a period.

[From the Congressional Record, Vol. 130, No. 13, pp. S1185-S1186--Senate, February 8, 1984]

S. 2278. A bill entitled the "Care for Chemically Dependent Veterans Act"; to the Committee on Veterans' Affairs.

CARE FOR CHEMICALLY DEPENDENT VETERANS ACT

Mr. BOSCHWITZ. Mr. President, today I am introducing legislation that will make permanent the Veteran's Administration's authority to place chemically dependent veterans in non-VA community facilities.

Currently, this program is operating under a pilot authority that is due to expire September 30, 1985. The program was begun in 1979 in response to inadequacies in the VA's chemical-dependency program.

Mr. President, I have been in contact with VA officials in medical facilities around Minnesota concerning this program. And their response to my questions about how well it is working have been overwhelming. The typical comment has been: "It's the best thing ever to happen to the VA's chemical-dependency program." Veterans who have been through it have made the same sort of comment.

The VA, and the rest of us, have come a long way in our willingness to treat those who suffer from alcohol or drug dependencies. It was not so long ago that alcoholics were considered willful malingerers, and medical treatment consisted of drunk tanks only. Today, we recognize that chemical dependency is a disease, and should receive medical care accordingly.

I believe the VA's current halfway-house approach of treatment and rehabilitation should be encouraged and continued. And that is why I am introducing my bill today. I hope we on the Committee on Veterans' Affairs can address this issue this year, and remove any uncertainty about the program's future.•

[No. 79]

Office of the
Administrator
of Veterans Affairs

Washington, D.C. 20420

Veterans
Administration

MAY 21 1984

Honorable Alan K. Simpson
Chairman, Committee on Veterans'
Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to respond to your request for the views of the Veterans Administration (VA) on S. 2278, 98th Congress, a bill entitled "Care for Chemically Dependent Veterans Act." The VA supports the enactment of this proposal.

This bill would make permanent the VA's pilot program to contract for care, treatment, and rehabilitative services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities for eligible veterans suffering from alcohol or drug dependence or abuse disabilities. That authority expires on September 30, 1985. While the VA favors this provision, we would recommend that the authority only be extended for an additional three years.

Our evaluation of this program, which included a followup of veterans eighteen months after treatment, has shown that the contract authority has been, and would continue to be, a valuable, cost-effective modality to supplement VA treatment and rehabilitation of certain veterans. VA treatment program directors, as well as non-VA community program directors, enthusiastically endorse the continuation of this program.

Since April 1980, the VA has operated a program authorized by Public Law 96-22 which provides treatment and rehabilitation in community contract facilities, such as halfway houses, to certain veterans suffering from alcohol and drug dependence. In authorizing the establishment of this pilot program, Congress called for the VA to plan and operate a pilot program in order to demonstrate both the medical advantages and cost effectiveness of such care in contrast to comparable care rendered in VA facilities. Congress also directed that VA report by March 31, 1984, on the operation of this pilot program.

Our study has shown that this program has been of greatest benefit to veterans who are essentially alienated from society, deficient in job skills, and without family support. Not only does this program reduce costs to the VA by providing treatment to a veteran in a residential environment rather than in a hospital, but it appears to have resulted in reductions in expenditures for additional treatment. In fact, this benefit shall increase with time due to the reduced recidivism rate among the halfway house group. Furthermore, this program is also proving that the halfway house is more successful as a treatment modality than a hospital in facilitating the reentry of the veteran into the community and job market and in the acquisition of self-help and job skills.

Veterans who have been outplaced into community facilities under this program have been more seriously addicted and less able to function independently in society than the VA's substance abuse population as a whole. Following the treatment of eligible veterans at halfway houses under VA contracts, a number of important improvements occurred, including maintenance of a drug-free environment, employment, self-help, and coping skills.

We estimate that the cost of continuing this program to be $6.1 million for fiscal year 1986 and approximately $24.4 million for fiscal years 1986-1989.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

Everett Alvarez

Deputy Administrator • For

HARRY N. WALTERS
Administrator

II

98TH CONGRESS
2D SESSION

S. 2514

To amend title 38, United States Code, to enhance the management of Veterans' Administration medical treatment programs by providing for the referral of veterans to non-Veterans' Administration entities and arrangements for additional necessary services, to revise and clarify the authority for the furnishing of care for veterans suffering from alcohol or drug dependence, to require the Administrator to establish the position of Associate Director for Post Traumatic Stress Disorder, to require the Administrator to submit a report to Congress regarding programs of the Veterans' Administration providing hospice and respite care to certain veterans, and to authorize the Administrator of Veterans' Affairs to provide telecaption television decoders to totally deaf veterans in certain cases, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 30 (legislative day, MARCH 26), 1984

Mr. SIMPSON introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

A BILL

To amend title 38, United States Code, to enhance the management of Veterans' Administration medical treatment programs by providing for the referral of veterans to non-Veterans' Administration entities and arrangements for additional necessary services, to revise and clarify the authority for the furnishing of care for veterans suffering from alcohol or drug dependence, to require the Administrator to establish the position of Associate Director for Post Traumatic Stress Disorder, to require the Administrator to submit a report to Congress regarding programs of the

Veterans' Administration providing hospice and respite care to certain veterans, and to authorize the Administrator of Veterans' Affairs to provide telecaption television decoders to totally deaf veterans in certain cases, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) this Act may be cited as the "Veterans' Administration Health Care Amendments of 1984".

(b) Except as otherwise specifically provided whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

REFERRALS AND ARRANGEMENTS FOR COMMUNITY SERVICES

SEC. 2. (a) Chapter 73 is amended by adding at the end of subchapter 1 the following new section:

"§ 4120. Referrals and arrangements for community services

"In order to enhance the management of Veterans' Administration care and treatment programs, the Administrator shall designate one office in each Veterans' Administration health care facility and in central office to coordinate and make arrangements for the provision of referral services to assist veterans, to the maximum extent practicable, in obtaining health and health-related services from sources outside the Veterans' Administration, not at Veterans' Administration expense, when such services are reasonably necessary in the treatment of veterans eligible for care under chapter 17 of this title. In carrying out this section, the Administrator shall place particular emphasis on the needs of veterans with service-connected disabilities rated at 50 per centum or more and veterans age sixty-five or older.".

(b) The table of sections at the beginning of chapter 73 is amended by adding after the item relating to section 4119 the following:

"4120. Referrals and arrangements for community services.".

ALCOHOL TREATMENT AND REHABILITATION

SEC. 3. (a) Section 620A is amended—

(1) by amending paragraph (1) of subsection (a) to read as follows:

"(1)(A) The Administrator, in furnishing hospital, nursing home and domiciliary care, and medical and rehabilitative services under this chapter, may contract for care and treatment and rehabilitative services in halfway houses, at such per diem rates as the Administrator shall by regulation prescribe consistent with prevailing rates in the community.

"(B) For the purposes of this section, the term 'halfway house' means a treatment facility not under the direct jurisdiction of the Administrator, offering a community based, peer group oriented, residential program of treatment and rehabilitation for alcohol or drug dependence or abuse disabilities, which provides food, lodging, and supportive services in a drug- and alcohol-free environment for veterans recovering from active alcohol or drug abuse.

"(C) The maximum period for one treatment episode under the authority established by paragraph (1)(A) of this subsection shall be limited to sixty days.";

(2) by redesignating paragraph (2) of subsection (a) as paragraph (D);

(3) by striking out subsection (e);

(4) by redesignating all subsections, paragraphs, clauses, and cross-references accordingly; and

(5) by adding at the end the following new subsection:

"(b) The Administrator shall prescribe regulations, not later than twelve months after the date of enactment of this Act—

"(1) to establish maximum periods of treatment and rehabilitation for alcohol or drug dependence or abuse disabilities of a veteran eligible for care under this chapter consistent with the average periods of such treatment and rehabilitation experienced in programs not administered by the Veterans' Administration, to include specific maximum periods for—

"(A) detoxification to stabilize the veteran's condition;

"(B) acute inpatient care and treatment;

"(C) additional extended care and treatment in cases involving multiple and complex diagnoses; and

"(D) outpatient care and treatment including appropriate referral services under section 4120 of this title; and

"(2) to ensure that individual treatment plans are developed, implemented, and monitored (including at least one year of followup monitoring after discharge from inpatient care and treatment) for each veteran receiving care for alcohol or drug dependence or abuse disabilities.";

(6) in paragraph (5) of subsection (a) (as redesignated by paragraph (3) of this subsection), by striking out "authorized by this section" and inserting in lieu thereof "authorized by the amendment made by section 104 of Public Law 96–22 (93 Stat. 50)".

(b) Not later than September 30, 1984, and on September 30 of each subsequent year, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a comprehensive survey of all Veterans' Administration alcohol and drug treatment and rehabilitation programs, identifying by facility, the number of beds involved, the number of patients and episodes of care (whether inpatient-acute, inpatient-rehabilitation, or outpatient), the specific treatment modalities employed, average lengths of stay, and staffing requirements, together with a national summary of such information. The third such report shall contain in addition information on the effectiveness of the care and treatment furnished to veterans for alcohol or drug dependence or abuse disabilities in light of the regulations promulgated and implemented under subsection (b) of section 620A (as amended by this section), including information on the use of differential diagnosis, case-management treatment, lengths of stay, discharge planning, methods of monitoring the use of halfway houses under the authority of section 620A, and referral and followup programs.

(c) The section heading of section 620A and the item relating to such section in the table of sections at the beginning of chapter 17 are each amended by striking out the semicolon and "**pilot program**".

MEDICAL AND REHABILITATIVE DEVICES

SEC. 4. Section 601(6)(A)(i) is amended by inserting "devices for the hearing-impaired in the case of any veteran who is totally deaf (including telecaptioning television decoders)," after "prosthetic appliances,".

POSTTRAUMATIC STRESS DISORDER

SEC. 5. (a) Section 4101 is amended by adding at the end thereof the following new subsection:

"(g)(1) The Administrator shall establish in the Mental Health and Behavioral Sciences Service of the Department of Medicine and Surgery a position to be known as Associate Director for Posttraumatic Stress Disorder (hereinafter in this subsection referred to as "Associate Director") and shall appoint an individual to serve in such position. The rate of basic pay of the Associate Director shall not be less than the minimum rate of basic pay payable for a position in chief grade under the physician and dentist schedule set out in section 4107(b)(1).

"(2) The Associate Director shall develop policies, provide guidance, and coordinate the provision of services for the treatment of Vietnam veterans with posttraumatic stress disorder, including care furnished in inpatient posttraumatic stress disorder units.

"(3) The Associate Director shall coordinate, by medical region, inpatient care for eligible veterans suffering from posttraumatic stress disorder, and shall take steps to ensure that the provision of such care includes the use of treatment plans, referral procedures, and posttreatment followup care.

"(4) The Associate Director shall conduct special education and training programs on posttraumatic stress disorder for appropriate employees of the Department of Medicine and Surgery, including programs on diagnostic criteria and methodologies, referrals, and the formulation and implementation of treatment plans and followup care.

"(5) The Chief Medical Director shall establish a task force on the care and treatment of posttraumatic stress disorder. The task force shall include health care employees of the Veterans' Administration who are involved in the treatment or care of veterans suffering from posttraumatic stress disorder. The task force shall advise the Chief Medical Director on policies regarding—

"(A) the use of appropriate treatment modalities and the development of standards governing lengths of stay of veterans in Veterans' Administration health care facilities for care and treatment for problems related to posttraumatic stress disorder;

"(B) the coordination of treatment of posttraumatic stress disorder patients after discharge from inpatient care;

"(C) the monitoring and evaluation of treatment programs for posttraumatic stress disorder patients;

"(D) the conduct of health-services research making comparisons among various treatment modalities for posttraumatic stress disorder to determine proper treatment methods and length of stay;

"(E) ensuring proper diagnosis of posttraumatic stress disorder at all medical facilities including those which do not have programs dedicated specifically to the care and treatment of posttraumatic stress disorder; and

"(F) the necessity of, and appropriate standards governing referral of patients, including those receiving vocational rehabilitation in domiciliaries.".

(b) Not later than nine months after the date of enactment of this Act, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report evaluating the results of the implementation of this subsection.

REPORT ON VETERANS' ADMINISTRATION PROGRAMS FOR TERMINALLY ILL AND CERTAIN OTHER VETERANS

SEC. 6. (a) Not later than September 30, 1985, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report regarding programs of the Veterans' Administration (1) to furnish palliative and supportive care to terminally ill veterans and supportive care to members of such veterans' families, and (2) to furnish care to terminally and chronically ill veterans for brief periods in part for the purpose of providing a respite for members of the veterans' families in order to encourage them to maintain the veterans in their homes (in order to obviate the need for institutional care) to the maximum extent practicable.

(b) The report required by subsection (a) shall include—

(1) a review of Veterans' Administration policies and guidelines on the provision of care described in subsection (a);

(2) a review of the care furnished to the veterans described in paragraph (a) and any treatment modalities used to furnish such care, including a description of the services furnished in connection with such care;

(3) a comparison of the care provided to terminally ill veterans in hospice and nonhospice treatment programs, including a comparison of the routine and ancillary services furnished as hospice care and the routine and ancillary services furnished to terminally ill patients in nonhospice treatment programs;

(4) an analysis of the lengths of stay of, and cost of care provided to, chronically and terminally ill veterans in programs described in subsection (a);

(5) an evaluation of whether and how the provision of care to terminally and chronically ill veterans described in subsection (a)(2) helps to obviate or delay

the need for institutionalizing such veterans for a prolonged period;

(6) an explanation of how the care described in subsection (a) is or will be included in the overall plans of the Veterans' Administration for providing health care to elderly veterans in the future and the extent to which plans to furnish hospice and respite care are included in such plans;

(7) a review of the steps taken to coordinate the provision of the care described in subsection (a) with community providers of similar care; and

(8) proposals for such administrative or legislative action as the Administrator may deem appropriate in light of the findings and conclusions of such report.

[From the Congressional Record, Vol. 130, No. 40, pp. S3533-S3536--Senate, March 30, 1984]

VETERANS' ADMINISTRATION HEALTH CARE AMENDMENTS OF 1984

Mr. SIMPSON. Mr. President, as chairman of the Committee on Veterans' Affairs, I am today introducing S. 2514, the proposed Veterans' Administration Health Care Amendments of 1984. This legislation is designed to clarify and improve certain health care programs and services currently provided and administered by the Veterans' Administration. The central purpose of this initiative is to continue to obtain maximum use of VA health care resources and to improve the quality of health care services by providing the most appropriate kinds and levels of care to certain specific veteran populations which are already receiving VA health care services. Our measure promotes a more concentrated effort to coordinate complex types of care and a more efficient use of resources by targeting appropriate kinds of services to match veterans' specific needs. Specific veterans populations who would benefit from the legislation would be those service-connected veterans, elderly veterans, Vietnam veterans with post traumatic stress disorder (PTSD), veterans who are totally deaf, and veterans with alcohol-related disorders.

SUMMARY OF PROVISIONS

Mr. President, the five substantive provisions of my bill would:

First, authorize the Veterans' Administration to arrange for certain health and health-related services in local communities at no expense to the VA but which would allow the VA to further manage a veteran's care.

Second, provide that the Administrator of Veterans' Affairs shall coordinate care for veterans suffering from alcohol dependence.

Third, provide the Administrator with specific authority to provide for the hearing-impaired, including telecaptioning television decoders, to veterans who are totally deaf.

Fourth, direct the Administrator to establish the position of Associate Director for Post Traumatic Stress Disorder (PTSD) in order to clarify VA policy, provide guidance, and coordinate care for Vietnam veterans suffering from PTSD.

Fifth, direct the administrator to submit a report to Congress regarding VA hospice and respite programs for terminally ill and chronically ill veterans.

VA/COMMUNITY COORDINATION PROGRAMS' OFFICE

Mr. President, a major problem in caring for geriatric veterans is to coordinate the delivery of the various health care services which are often needed. Not all veterans are eligible for all types of care and not all VAMC's provide all types of care, therefore some reliance on community resources may be necessary.

There is presently considerable interest within the VA to cooperate with other public and private institutions in order to improve the delivery of health care services. Under current law, the VA is authorized to participate in the cooperative health manpower education program (CHMEP), with public institutions, nonprofit corporations, and others by establishing cooperative health care personnel education programs in areas geographically remote from major academic health centers. The purpose of these programs is to improve the competencies and performance of practicing health care personnel in areas underserved by the health care system.

The purpose of this provision would be to provide the VA with enhanced authority to manage a veteran's program of treatment under varying circumstances including such times when a certain service is not offered by the VA, or times when a veteran may not be eligible for a certain service or times when due to a great distance between the veteran's home and the VA medical center close monitoring of a chronic condition is impractical. This legislation would establish a VA/community office within each medical center that would provide as part of discharge planning and ongoing care management, referral services to and help for veterans to negotiate the system in order to take advantage of certain health services currently available in local communities that would certainly enhance a veteran's treatment. Section 3 of the measure I am introducing today, would particularly benefit elderly veterans who reside in rural areas and who receive VA health care services, and who could benefit from supplemental services that exist in the community.

CLARIFY ALCOHOL TREATMENT AND REHABILITATION

Mr. President, according to the National Institute of Medicine, alcohol abuse and alcoholism cost America $60 billion a year. Twenty percent of our total national expenditure for hospital care is alcohol related. The VA treats approximately 100,000 veterans each year for alcohol-related disorders in its 102 alcohol treatment units and other programs out of a total of about 3 million veterans treated. The VA's most recent report on alcoholism and VA patients "1980 Supplement to Alcoholism and Problem Drinking 1970-1975," notes that alcoholism-related disorders are the second largest category of diagnoses of patients discharged from VA hospitals, next to heart disease. When "problem drinkers"—those whose current treatment or prognosis are complicated by drinking—are added to those defined as "alcoholics," the percentage in VA hospitals was 26 percent in 1980. And the percent of alcoholics or problem drinkers among hospitalized Vietnam-era veterans was 38 percent.

The VA's specialized alcohol dependence treatment programs emphasize short-term inpatient hospitalizations during which time a comprehensive evaluation is made including biomedical, social, and vocational skills assessments. An individualized treatment plan is formulated, including treatment for other significant medical, surgical, or mental health problems. According to the VA, the trend in VA care is for shorter inpatient stays and proportionately more of the needed treatment to be provided in an outpatient or ambulatory setting.

Mr. President, I very seriously considered including in section 4 of the bill I am introducing today a provision which would unify alcohol treatment goals within the VA by mirroring the VA's current policy of emphasizing short-term inpatient stay and making maximum use of outpatient and other forms of ambulatory care for alcohol treatment and rehabilitation. That provision would have provided the VA with specific authority to provide up to 7 days detoxification, 28 days inpatient treatment, 15 weeks for rehabilitation (if necessary) and followup outpatient or half-way house care for alcohol treatment and rehabilitation. The VA would have been directed to provide a minimum of 1 year of followup to all veterans who had completed the inpatient treatment program. The purpose of this provision was to require the VA to put into practice what is reflected in its program guide and by other Government and private-sector alcohol treatment programs generally and to address three specific goals: First, to move the veteran through the treatment phases in a timely manner, second, to take into account other possible medical complications when formulating the veteran's treatment plan; and third, to provide the essential coordination of rehabilitative services and reintegration into the veteran's local community. I believe these goals are especially critical to the veteran's chances of recovery.

In an attempt to be responsive to the Veterans' Administration and others concerned about the VA's efforts to treat veterans with alcohol dependence and abuse disabilities, I have decided not to specify the limitations in the bill but instead to include in section 4 of the bill I am introducing today a requirement that the Administrator prescribe regulations to establish maximum periods of treatment and rehabilitation for alcohol or drug dependence or abuse disabilities consistent with the average period of such treatment and rehabilitation experienced in programs not administered by the VA. These regulations are to include maximum periods for detoxification, acute inpatient care, additional extended care for cases involving multiple and complex diagnoses, and outpatient care. Regulations on the use of individualized treatment plans, their development and implementation, and including at least 1 year of followup monitoring would also be prescribed. Rather than specifying the limits of each treatment phase in the legislation, the requirement that the VA prescribe regulations would provide the VA with the flexibility to exercise their own medical judgment in setting forth the parameters of the program. It is my expectation and hope that the VA will proceed expeditiously to prescribe these regulations and that further legislation will not be necessary.

MEDICAL AND REHABILITATION DEVICES FOR THE HEARING IMPAIRED

Mr. President, the VA issues over 1 million prosthetic and sensory aids to eligible veterans each year; including aids for the blind, artificial limbs, wheelchairs, auto adaptive equipment, hearing dogs, TTY's (machines which type out incoming phone messages), automatic page turners, and many more items. However, a VA General Counsel opinion of July 9, 1980, has prohibited a totally deaf veteran from receiving a telecaption TV decoder which adapts a TV set to receive broadcasts with subtitles unless a veteran has a "morbid mental condition." This would seem to unfairly discriminate against the deaf veteran by requiring that he become socially disoriented to the degree that he is considered mentally ill prior to the receipt of a telecaption device. No such requirement exists for veterans who receive other medical devices.

Section 5 of the legislation I am introducing today would be a practical technical amendment to clarify the eligibility of a totally deaf veteran to receive a telecaption TV decoder as part of other medical and rehabilitative services for which he or she is already eligible. This measure would make the issuance of this device consistent with VA policy on other prosthetics and sensory aids under section 601(6) of title 38, United States Code.

INPATIENT TREATMENT FOR POST-TRAUMATIC STRESS DISORDER

Mr. President, 10 VA medical centers have set up special inpatient units for Vietnam veterans with posttraumatic stress disorder (PTSD), in order to provide inpatient treatment for veterans whose PTSD is too severe to be treated by vet centers or outpatient clinics. Treatment includes a combination of individual, group, and family therapy, and certain special therapeutic programs. The VA has no policy on these special units which have been developed as a result of local medical center initiatives. Neither the Readjustment Counseling Service in charge of vet centers nor the Mental Health and Behavioral Sciences Services in charge of all other mental health services is managing or coordinating the care provided in these inpatient units. The measure I am introducing today would be an important step toward coordination of readjustment services for Vietnam vets with PTSD.

Section 6 of my proposal would direct the Administrator to establish an Associate Director for PTSD under the Mental Health and Behavioral Sciences Service in order to clarify policy, provide guidance, coordiante care for veterans with PTSD and to educate VA health care personnel about PTSD. The VA would also be required to submit a report to Congress on its efforts in this regard.

CARE FOR TERMINALLY ILL VETERANS AND RESPITE FOR CHRONICALLY ILL

Mr. President, hospice care is increasingly recognized as a most compassionate alternative manner of caring for the terminally ill. Such care provides supportive counseling and pain relief for patients who have less than 6 months to live and it is designed to assist patients to remain at home as long as is possible.

The Health Care Financing Administration (HCFA) has recently published final regulations for payment of hospice care under medicare and the Joint Commission on Accreditation of Hospitals (JCAH) has created an accreditation program for hospice care and has developed a hospice standards manual. The VA has one inpatient program and 15 additional programs of hospice care for terminally ill veterans. An evaluation of the inpatient program, which is located at the Wadsworth VA Medical Center, has just been completed.

Section 7 of this measure would require the VA to report to Congress on all its efforts to provide care to the terminally ill, including an evaluation of the appropriate kind and level of services provided, an assessment of the most cost-effective mix of such services; and the advantages and disadvantages of different forms of hospice-like care.

The VA also has one inpatient respite program for terminally ill and chronically ill veterans who reside at home and who already have access to primary caregivers. This program provides the veterans with short-term, intermittent and occasional stays at VA facilities in order to enable the caregivers to "take a break" from their constant care and monitoring of the veterans, thus providing incentives for the caregivers to continue to provide care and thus preventing a certain number of nursing home admissions. Our measure would also require the VA to report to Congress on its efforts to provide respite care, the scope of the efforts, its cost-effectiveness, and its relationship to and impact on nursing home admissions.

CONCLUSION

Mr. President, as I have mentioned, the provisions of this bill would promote the VA's ability to even better manage care currently provided to our Nation's veterans and improve its ability to provide the most appropriate kinds and levels of care, especially to service-connected veterans, elderly veterans, veterans with alcohol-related disorders, and veterans who are totally deaf. I do look forward to working on this measure with the ranking minority member of the committee, my good friend from California (Mr. CRANSTON), other members of the committee, the VA, the veterans' service organizations, and others who share my interest in improving and enhancing the very fine services of the VA's Department of Medicine and Surgery. On April 11 the committee will hold hearings on this and certain other health-related legislation pending in the committee.

Mr. President, I ask unanimous consent that the text of S. 2514 be printed in the RECORD at this point.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

* * * * *

[No. 85]

Office of the
Administrator
of Veterans Affairs

Washington, D.C. 20420

Veterans
Administration

JULY 16 1984

Honorable Alan K. Simpson
Chairman, Committee on
Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to respond to your request for the views of the Veterans Administration (VA) on S. 2514, 98th Congress, the proposed Veterans' Administration Health-Care Amendments of 1984.

S. 2514 is intended to effect certain improvements in the management of VA medical programs. Its major provisions would: (1) direct VA to make arrangements for referring certain veterans to community sources for care, (2) mandate the establishment of policies governing VA care for veterans suffering from alcohol or drug dependence and post-traumatic stress disorder, (3) require VA to submit a report to Congress on VA care for the terminally ill and on "respite" care; and, (4) authorize VA to provide certain devices for totally deaf veterans. In sum, we do not believe the central provisions of this legislation are needed or desirable, and, accordingly, we oppose the enactment of S. 2514.

Section 2 of S. 2514 would add a new section 4120 to title 38, United States Code, which would require the VA to designate an office in each health care facility and in the Central Office to coordinate and make arrangements for the provision of referral services to veterans in obtaining health-related services from non-VA sources available in the community. The VA favors the apparent purpose of this provision to encourage greater coordination and use of private non-Federal resources to assist veterans who need additional care following their discharge from VA facilities. It does not appear that this provision would enhance VA's authority in this area. The VA provides referral services which are already routinely furnished by various personnel, including nurses and social workers, at all VA medical centers. This is currently an activity which comes under the umbrella of the Information and Referral Program that is the subject of an interagency agreement. We see no need for legislation which would simply provide authority for ongoing activities.

To establish an office in each VA medical center and in the Central Office to accomplish the purposes of this provision would entail costs of some $4.87 million for the first year, and five-year costs of some $54.78 million.

Section 3 of this bill would extend the VA's authority to provide contract care to veterans in halfway houses for alcohol or drug dependence and would mandate certain actions in the administration of the VA's care of veterans suffering such disabilities. We favor an extension of VA's authority under section 620A of title 38, United States Code, as provided for in section 5 of S. 2269 and in S. 2278. However, we favor a three-year extension of the program in order to allow periodic review of the program's effectiveness.

We object to the alcohol treatment and rehabilitation provisions of S. 2514 because of requirements which tend to prescribe in statute the manner in which VA should treat these disorders. For example, this provision rigidly limits halfway house treatment for each episode to 60 days. It is already our policy to review all cases at a 60-day point of length of stay, and limit further care based on an individual case review. The average length of stay for our contract halfway house program is 41 days. However, 12 percent of our patients do exceed 60 days based on their need for a longer period of care. The imposition of a 60-day limit on this program would compromise the clinical management of this significant number of cases.

This section would also require the VA to promulgate regulations to govern the VA-operated programs for care of veterans for alcohol and drug dependence disorders. Regulations on the use of individualized treatment plans and on the maximum duration of care based on non-VA program averages would be mandated.

We should point out that VA policies do address the apparent purposes of this provision. We have published a program guide which recommends procedures for establishing and operating these treatment programs. Reporting mechanisms permit us to monitor program operations. Each VA medical center has utilization review and quality assurance programs. Further, standards are also included in accreditation requirements of the Joint Commission on Accreditation of Hospitals.

While we recognize that an effort has been made to reserve discretion to the VA regarding the specific content of the proposed regulations, this section of the bill raises troublesome questions. Thus, we do not believe that Federal regulations are a necessary or appropriate vehicle for the establishment of medical policies. Likewise, we do not believe legislation is needed to realize improvements in lengths of stay and treatment planning in these programs. Accordingly, although we concur with the broad aims underlying this provision, we do not believe a statutory response is desirable and oppose section 3 of S. 2514.

Extension of VA's contract authority under 38 U.S.C. § 620A would result in costs of some $6.1 million for the fiscal year 1986, and five-year costs of approximately $24.4 million.

Section 4 of the bill is apparently intended to authorize the VA to furnish any totally deaf veteran with a "telecaptioning television decoder" and other "devices for the hearing impaired." VA already has authority to furnish devices for the hearing impaired based on medical need. As such, we believe this provision is unnecessary and do not favor its enactment. If section 4 is not simply a technical amendment, as described in the Congressional Record, but a provision that would seek to eliminate medical need as a basic criterion of eligibility for one group of veterans, we would oppose its enactment.

Section 5 of this bill would require the VA to establish a position of Associate Director for Post-Traumatic Stress Disorder (PTSD) in the Mental Health and Behavioral Sciences Service of the Department of Medicine and Surgery to develop policies, provide guidance, and coordinate services for Vietnam-era veterans with post-traumatic stress disorder, and to educate VA health care personnel about PTSD. VA would also be required to establish a task force to develop a series of specified policies concerning PTSD care and research.

The subject of VA care for Vietnam veterans suffering from PTSD is a dynamic area within VA. It is an area which is rapidly evolving and may have given rise to a perception that legislation is needed. We see no need for this legislation, however. The VA has in recent years taken extraordinary new initiatives concerning the effects of PTSD, not only on Vietnam veterans, but all combat veterans. This area is central to the mission of the Agency.

A number of VA facilities have established PTSD inpatient units. Centrally directed staffing guidelines for such establishment and operation of dedicated PTSD inpatient units have been developed and are presently under review. Since the institution of the Vet Centers in late 1979, and the promulgation of an official diagnosis for the condition by the American Psychiatric Association in 1980, recognition of PTSD and institution of effective services in Vet Centers and VA mental health clinics have greatly increased.

In the VA Central Office, PTSD treatment is coordinated through our Psychiatry Service, which is in the Mental Health and Behavioral Sciences Service. Our Readjustment Counseling program also provides counseling assistance to many veterans suffering from PTSD. It is important to recognize that, unlike many other psychiatric conditions, post-traumatic stress disorder is one manifestation of a normal recovery process, in reaction to an external set of stressors. The disorder may be manifested in widely varying degrees of severity, requiring widely differing types of psychiatric care, psychotherapy, and counseling. Given the complex nature of this disorder, we urge that you reconsider the proposal to mandate that VA establish a specific position that separates PTSD care from other aspects of psychiatry. This step would be contrary to good management practice. The delivery of PTSD care and education is being furnished effectively on the basis of close cooperation of several services--Mental Health, Social Work, and Readjustment Counseling, and the Office of Academic Affairs. We believe that an effort to create a statutory position, with over-arching responsibility within one element, represents a poor management mechanism and an undesirable legislative precedent.

As regards what appears to be the major thrust of this provision, we submit that delivery of effective PTSD care is not simply a matter of developing centralized policies, but perhaps more important, a matter of continuing medical education. Such education efforts are a priority for us. Specialized education programs on diagnosis and care of PTSD have been and will continue to be offered under the auspices of our Regional Medical Education Centers, for example. We do not seek to minimize the importance of managing and coordinating PTSD care to the extent possible. We simply urge that the Agency be permitted to focus its expertise in accordance with evolving needs as determined by the Chief Medical Director. In essence, we do not believe that section 5 of S. 2514 is necessary or desirable. Accordingly, we do not support it.

Finally, S. 2514 would require the VA to submit a report by September 30, 1985, to both Veterans' Affairs Committees on programs to provide care to terminally ill veterans and their families, and care for veterans for brief periods in order to provide a respite to veterans' families. We have no objection to reporting on care provided terminally ill patients.

We project that enactment of S. 2514 would result in costs of some $6.557 million in FY 1985 and five-year costs of approximately $82.469 million. The methodology on which these estimates are based is enclosed.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

Everett Alvarez / Deputy Administrator • For
HARRY N. WALTERS
Administrator

Enclosure

Veterans
Administration

Memorandum

Date: APR 27 1984

To: Deputy Assistant General Counsel (023B)

From: Chief Medical Director (101E)

Subj: S. 2514 cost estimate

Estimated costs for provisions of S. 2514 are summarized below. For a detailed explanation of these costs and the methodology used for each, please refer to the attached memoranda.

VA/Community Coordination: Designation of one office in each VAMC and in VACO for provision of referral services.

FY	Costs (in thousands)
1985	$ 4,873
1986	9,168
1987	13,580
1988	13,580
1989	13,500
Total	$54,781

Drug and Alcohol Treatment: Provision of contract care to veterans in halfway houses.

FY	Costs (in thousands)
1985	$ -0-
1986	6,100
1987	6,100
1988	6,100
1989	6,100
Total	$ 24,400

VA FORM 2105
MAY 1983

Devices for the Deaf: To provide devices for the hearing impaired veteran who is totally deaf (including telecaptioning decoders).

FY	Costs (in thousands)
1985	$ 1,182
1986	314
1987	13
1988	14
1989	15
Total	$ 1,538

Management of PTSD Care: To establish a position of Associate Director for PTSD.

(Costs in Thousands)

FY	Director	*Related Costs
1985	$ 110	$ 227
1986	85	227
1987	85	227
1988	85	227
1989	85	227
Total	$ 450	$1,135

*(Includes one secretary (GS-7), associated costs of Director's education and training activities, task force activities.)

Report on Respite Care: Report on VA programs for terminally ill and others.

1 year cost - $165,000

2. Estimated total five-year cost of S. 2514 is as follows:

VA/Community Coordination	$54,781
Drug and Alcohol Treatment	24,400
Devices for the Deaf	1,538
PTSD Management	1,585
Report on Respite Care	165
Total	$ 82,469

John A Gronvall, for
DONALD L. CUSTIS, M.D.

Attachments

Veterans Administration

Memorandum

Date: April 5, 1984

To: Legislative Affairs Staff (101E)

From: ACMD for Geriatrics and Extended Care (18B)

Subj: Draft Legislation, 99th Congress, 2nd Session, "Veterans Administration Health Care Amendments of 1984," Senator Simpson

1. Referrals and Arrangements for Community Services

    a. Section 3(a) proposes that the VA designate one office in each VAMC and in VACO for the provision of referral services to assist veterans in obtaining health and health-related services from sources outside the VA.

    b. This proposal would enhance the established Information & Referral Program and could provide the foundation for future community collaborative efforts through enhanced program planning and development.

    c. The costs/savings estimate for this section of the proposed bill follows:

Fiscal Year	Benefits Costs/Savings (in thousands)	Staff Years
1985	$ 4,873	166
1986	9,168	304
1987	13,580	416
1988	13,580	416
1989	13,580	416
	$ 54,781	1,720

    d. We recommend that the Department support this section of the proposed bill.

2. Report on VA Programs for Terminally Ill and Certain Other Veterans

    a. Section 6(a) proposes that a report be submitted by Sept. 30, 1985, to the Committees on Veterans' Affairs of the Senate and House of Representatives regarding the VA programs: (1) to furnish palliative and supportive care to terminally ill veterans and supportive care to the veteran's family; and (2) to furnish care to terminally and chronically ill veterans for brief periods for the purpose of providing a respite for members of the veterans' families in order to obviate the need for institutional care.

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b. Section 6(b) specifies that the report include:

   (1) A review of the policies and guidelines for the provision of palliative/supportive and respite care;

   (2) A review of the care furnished, treatment modalities used, and a description of the services furnished to veterans in the palliative/support and respite care programs;

   (3) A comparison of (a) care provided and (b) routine and ancillary services furnished to terminally ill veterans in hospice and non-hospice programs;

   (4) An analysis of lengths of stay and costs of care for veterans in the palliative and respite care programs;

   (5) An evaluation of whether and how respite care helps to obviate or delay the need for prolonged institutionalization;

   (6) Plans for furnishing hospice and respite care;

   (7) Plans to coordinate hospice and respite care with community providers;

   (8) Proposals for administrative or legislative action based on the findings and conclusions of the report.

c. The basis for the comparison for requirement (3) and the analysis for requirement (4) for the palliative programs will be the evaluation of the Palliative Treatment Program at the VAMC West Los Angeles which was established in March 1980 using a randomized controlled study design. Data collection was completed in September 1982. Portions of the study are scheduled to continue through April 1984, including the analysis of hospice costs compared with the costs of traditional care. A report from the Palliative Treatment Program comparing treatment modalities used, services furnished, routine and ancillary services furnished in the hospice, and traditional care was forwarded to the Senate Veterans' Affairs Committee in February 1984.

d. There is no available data base for the analysis for requirement (4) for respite care as this has not been a formally recognized program in the VA. By requiring such an analysis, the proposed bill seems to implicitly acknowledge the legitimacy of providing respite care under VA's general authority to provide medical care. A special study and analysis will have to be conducted of respite care, that is a planned admission to institutional care, furnished to veterans outplaced in the community under VA outpatient programs such as Hospital Based Home Care, SCI Home Care, Home Dialysis, Day Hospital, and Day Treatment Centers.

e. Because of the limited provision of respite care by the VA, there is insufficient data available from past or present activity to conduct a valid evaluation for requirement (5). We recommend that this requirement be deleted or modified to require "an estimate of the potential for respite care to obviate or delay the need for prolonged institutionalization."

f. The costs/savings estimate for this section of the proposed bill follows:

Fiscal Year		Benefits Costs/Savings (in thousands)	Staff Years
1985		165	4
	Total	$165	4

g. We recommend that the Department not object to this section of the proposed bill.

JOHN H. MATHER, M.D.

REFERRALS AND ARRANGEMENTS FOR COMMUNITY SERVICES, SEC. 3(a)

Cost Methodology*

1. Establish one unit in each VAMC during a three year period starting with Category 1 & 2 VAMCs	
2. Projected staffing per VAMC - FTEE	
Category 1 & 2 VAMCs (81)	3
Category 3 & 4 VAMCs (85)	2
3. Projected personal services cost per VAMC	
Category 1 & 2 VAMCs (81) annual salary cost, $72,879; benefits at 12.5%, $9,110; total	$81,989
Category 3 & 4 VAMCs (85) annual salary cost, $53,457; benefits at 12.5%, $6,682; total	60,139
4. Travel .007 for staff visits to community services	
Category 1 & 2 VAMCs (81)	2,000
Category 3 & 4 VAMCs (85)	1,500
5. Medical care training	
Travel .007 - One 2-day national training session for 1 staff from each VAMC each year based on $400 air fare and $75 per diem for 3.5 days; total/participant	663
Travel .007 - Two 3-day regional training sessions per region each year for 2 staff from each VAMC based on $200 air fare and $75 per diem for 4 days; total/participant/year	1,000
6. Projected staffing VACO - FTEE	3
7. Projected personal services costs - VACO annual salary cost, $93,249; benefits at 12.5%, $11,656; total	104,905
8. Travel - program coordinator to one national training session and six regional training sessions based on $400 air fare and $75 for 4.5 days	3,066

*NOTE: This cost methodology is intended to be consistent with the implementation costs for the proposed Community Collaboration Offices (CCOs) in the current draft of the VA's Geriatric Plan.

REFERRALS AND ARRANGEMENTS FOR COMMUNITY SERVICES, SECTION 3(a)

Cost Methodology

Staff at Catagories 1 & 2 VAMCs (81)

Staff/VAMC	Grade/Step	FTEE	Annual Salary Rate	Annual Salary Cost
Program Coord.	13/5	1	$40,972	$40,972
Program Asst.	7/5	1	19,422	19,422
Typist	3/5	1	12,485	12,485
Sub Total				72,879
Benefits 12.5%				9,110
Total		3		$81,989

Staff at Categories 3 & 4 VAMCs (85)

Staff/VAMC	Grade/Step	FTEE	Annual Salary Rate	Annual Salary Cost
Program Coord.	13/5	1	$40,972	$40,972
Typist	3/5	1	12,485	12,485
Sub Total				53,457
Benefits 12.5%				6,682
Total		2		$60,139

VACO Staff

Staff	Grade/Step	FTEE	Annual Salary Rate	Annual Salary Cost
Program Coord.	14/5	1	$48,818	$48,818
Program Asst.	11/5	1	28,750	28,750
Secretary	5/5	1	15,681	15,681
Sub Total				93,249
Benefits 12.5%				11,656
Total		3		$104,905

REFERRALS AND ARRANGEMENTS FOR COMMUNITY SERVICES, SECTION 3(a)

Costing by Appropriation
($000)

	1985	1986	1987	1988	1989
MEDICAL CARE					
FTEE	165	301	413	413	413
Cost ($000)					
Pers. Svc.	4,509	8,385	11,993	11,993	11,993
Travel	110	206	290	290	290
Training	146	439	881	881	881
Sub Total	4,765	9,060	13,164	13,164	13,164
MAMOE					
FTEE	3	3	3	3	3
Cost ($000)					
Pers. Svc.	105	105	105	105	105
Travel	3	3	3	3	3
Sub Total	108	108	108	108	108
FTEE - Total	168	304	416	416	416
Costs - Total	4,873	9,168	13,580	13,580	13,580

REPORT ON VA PROGRAMS FOR TERMINALLY ILL AND CERTAIN OTHER VETERANS, SECTION 6

1.	Projected Staffing VAMCS - FTEE	2
2.	Projected personal services costs VAMCs - annual salary cost, $73,886; benefits at 12.5%, $9,236; total	$ 83,122
3.	ADP usage	20,000
4.	Projected staffing VACO - FTEE	2
5.	Projected personal services costs VACO - annual salary cost, $53,457; benefits at 12.5%, $6,682; total	60,139
6.	Supplies - forms, etc.	2,000

REPORT ON VA PROGRAMS FOR TERMINALLY ILL AND CERTAIN OTHER VETERANS, SECTION 6

Cost Methodology

VAMCs

Staff	Grade/Step	FTEE	Annual Salary Rate	Annual Salary Cost
Admin.	13/5	1.0	$ 40,972	$ 40,972
Typist	3/5	1.0	12,485	12,485
Sub Total				$ 53,457
Benefits 12.5%		2.0		6,682
Total				$ 60,139

VACO

Staff	Grade/Step	FTEE	Annual Salary Rate	Annual Salary Cost
Program Coord.	14/5	1.0	$ 48,818	$ 48,818
Typist	5/5	0.5	15,681	7,841
ADP Spec.	12/5	0.5	34,454	17,227
Sub Total				73,886
Benefits 12.5%				9,236
Total		2.0		$ 83,122

Veterans Administration

Memorandum

Date:

To: Legislative Affairs Staff (101E)

From: Director Prosthetics & Sensory Aids Service (121)

Subj: Review, Comments and Cost Estimate Concerning Draft Legislation for Hearing Impaired Veterans.

1. We have reviewed the proposed draft legislation to provide "devices for the hearing impaired in the case of any veteran who is totally deaf (including telecaptioning decoders)". We offer the following comments concerning this draft legislation:

a. Proposed language - concur as written. The specific intent of the draft legislation is to provide telecaptioning devices to totally deaf veterans. Section 601(6)(A)(i) is the only section where specific devices are identified as prosthetic services in Title 38 USC. Other available items for the hearing impaired are already provided as past medical services.

b. Five year cost estimate - our estimate is based on providing these devices to totally deaf veterans, those with a primary diagnoses for deafness rated 80% or more disabling. It includes both SC and NSC since the telecaptioning devices would be considered as part of medical services. The information concerning potential eligibles was obtained from the Statistics Review and Analysis Division, the item cost is based on the average cost of these items plus a small amount for inflation. The estimate assumes 100% participation by these veterans.

Potential Eligibles (SC & NSC)

Rating	March 1983	March 1984	
80%	2644	2678	
90%	20	19	
100%	48	39	
	2712	2736	(Increase 24)

1st Year
2189 (80% of 2736) x $540 = $1,182,060

2nd Year
571 (20% of 2736 + 24) x $550 =314,050

3rd Year
24 x $560 = 13,440

4th Year
24 x $570 = 13,680

5th Year
24 x $580 = 13,920

Total $1,537,150

VA FORM 2105
MAY 1983
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c. *Recommended Departmental Position:*

We recommended that DM&S support the draft legislation. A recent General Counsel opinion limits the provision of this device only to those veterans who suffer a "morbid" mental condition as a result of their deafness. We believe that the isolation which accompanies total deafness is so severe that it affects the mental and physical health of all totally deaf veterans. Therefore, we support the issuance of any device which reduces this isolation.

2. *If you have any questions concerning our comments or cost estimate, please contact my office.*

For and in the
absence of
FREDERICK DOWNS, JR.

Veterans
Administration

Memorandum

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Date: April 4, 1984

To: Legislative Affairs Staff (101E)

From: Acting Director, Mental Health and Behavioral Sciences Service (116A1)

Subj: Review, cost estimate, and brief comments concerning draft legislation.
Subtitle: Concerning language of Section V: Post-traumatic Stress Disorder

1. Provisions for a new Associate Director for Post-traumatic Stress Disorder are unlikely to make positive changes. The existing staff of Mental Health and Behavioral Sciences Service spends a substantial amount of time addressing the activities proposed in this legislation.

2. Establishment of a task force on the care and treatment of Post-traumatic Stress Disorder appears intended to bypass the role of Mental Health and Behavioral Sciences Service and of Professional Services in Central Office by directly advising the Chief Medical Director on policies concerning the listed items. Provision of a task force to advise Mental Health and Behavioral Sciences Service on these matters with travel funds may be of some value.

3. Establishment of the new position of Associate Director and of a task force seems unlikely to make a major change in DM&S operations. If DM&S chooses to increase its emphasis on the treatment of Post-traumatic Stress Disorder it has the authority to do so without additional legislation.

4. Five year cost estimates for the various provisions of this bill:

   (a) Position of Associate Director, Mental Health and Behavioral Sciences Service for Post-traumatic Stress Disorder including salary, physicians bonus, and moving costs, first year approximately $110,000; second through fifth years $340,000, secretary (GS-7) five years at $18,000 per year ($90,000).

   (b) Special education and training programs: Assuming that the Associate Director will conduct special education and training programs, the following assumptions will be made for cost estimates:

      (1) Training will be held in each medical district.

      (2) Approximately six facilities per medical district on the average will send a treatment team of five people for a total of thirty people per training episode. Assuming eight training episodes per year at a average cost of $500 per person plus $2,000 for trainers, yearly costs will be $136,000 per year or $680,000 for five years. It is important to observe that the Regional Medical Educational Centers (RMEC) have been providing training on the treatment of Post-traumatic Stress Disorder to medical center personnel. For purposes of this cost estimate, however, it is assumed that RMEC will continue its own program as a way to provide training support for Vet Centers, and advanced training for additional personnel or personnel who have completed training in their own medical district.

VA FORM 2105
MAY 1983
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(c) Task Force costs:

1. Assuming twelve members from the field and four from VACO.
2. Assuming three two day meetings per year for two years.
3. Assuming each meeting will be two and one half days.
4. Finally, assuming some task force site visits for program review purposes.
5. Assuming an average travel cost of $800.

a. Task Force meetings	$58,000
b. Task Force site visits	15,000
	$73,000

If the task force meets at the same rate for five years Total Cost equals $181,500.

ROBERT L. CUSTER, M.D.

TESTIMONY OF A PANEL CONSISTING OF DONALD L. CUSTIS, M.D., CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION, ACCOMPANIED BY D. EARL BROWN, JR., M.D., ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR; A. AUDLEY HENDRICKS, ASSISTANT GENERAL COUNSEL; AND MARJORIE R. QUANDT, ASSISTANT CHIEF MEDICAL DIRECTOR FOR ADMINISTRATION

Dr. CUSTIS. Thank you, Mr. Chairman. We are pleased to be here, Mr. Chairman, to present the views of the Veterans' Administration on the legislation pending before your committee. Our official testimony fully discusses each of these bills on today's agenda, so in the interest of time I will not repeat that analysis, but will make some brief opening remarks and my colleagues and I are prepared to respond to the questions concerning these measures.

These bills contain many attractive features, but in some instances we do have reservations and would counsel modification.

For example, in the case of S. 2514, we already have an extensive program of VA community interaction functioning primarily under our social work service. I would like to submit a summary of these activities for the hearing record. I think you will find them impressive. I would hope that in the coming weeks we could work with your staff to further develop this particular provision.

Mr. Chairman, S. 2514 is directed in part to concerns about VA drug and alcohol treatment and VA management of post-traumatic-stress disorder care. The proposal would have a number of far-reaching changes in the area of drug and alcohol treatment. Among these are provisions which would impose systemwide limitations on the clinical management of these patients.

We believe, Mr. Chairman, that the VA clinician who is providing all of the care of the individual patient should retain the flexibility to provide treatment based on his or her clinical judgment. We did hear, Mr. Chairman, and we appreciate the opinion you expressed on this subject in your opening remarks.

We in the Central Office do provide policy and guidelines and, of course, a clinician's decisions are subject to concurrent and retrospective review by peers and by local management authority. When a clinician's performance is found to be inadequate, corrective action is taken by local medical authorities.

We also believe that the advent of the DRG, resource allocation methodology, and the PRO, the peer review organization, on retrospective case review, in the VA medical district will have an additional positive impact on reducing average length of stay of patients in these categories.

We are not aware of any significant problems in the clinical management of these patients. However, I assure you, Mr. Chairman, that we do and will respond fully and take corrective action as troubles arise.

There are two measures before this committee dealing with the management of VA programs to provide care for veterans suffering from post-traumatic-stress disorder. A clinical understanding of this disorder as well as the development of appropriate treatment modality are rapidly evolving. We believe that the agency's record in this area reflects national leadership and amply demonstrates that legislation is really not necessary.

Accordingly, we urge that the agency be permitted to manage PTSD care in accordance with the evolving medical needs rather than pursue it in legislative mandates.

Mr. Chairman, section 5 of S. 2269 and S. 2278 would make permanent the VA's authority to contract in the community for halfway house treatment and rehabilitation for alcohol and drug dependence abuse disabilities. We fully support a 3-year extension in both of these initiatives. Our evaluation of this program shows that it provides an important treatment option for certain veterans who require care beyond existing VA hospital capabilities to restore the veteran to successful community functioning.

In the area of aging, section 3 of S. 2269, would authorize continuation of bereavement counseling for family members of veterans, including those participating in a hospice care program. This provision is needed to provide a fully functioning hospice care program and we fully support it.

Section 6 of S. 2269 provides important new authorities that will improve the effectiveness of VA security forces. We fully support these initiatives with a 3-year limit on special pay authority with the technical modifications discussed in our formal testimony.

Mr. Chairman, S. 2269 contains other important program improvements that we need to fully support or support with modifications as detailed in my formal statement.

S. 2210 places limits on VA's authority to provide automotive adaptive equipment for certain veterans who suffer from severe service incurred disabilities. This bill would provide that such equipment could not be provided more than once in a 3-year period, except when circumstances justify earlier vehicle replacement and would remove the bar to transfer such vehicles earlier.

Mr. Chairman, my formal testimony discusses this program and the VA's analysis of this provision.

Mr. Chairman, there are other important legislative initiatives before the committee that I have not discussed. However, in the interest of time, I will stop now and will be pleased to respond to any questions that you or other members of the committee might have.

Chairman SIMPSON. Thank you very much, Dr. Custis.

[The prepared statement of Donald L. Custis, M.D., Chief Medical Director, Veterans' Administration, follows:]

PREPARED STATEMENT OF DONALD L. CUSTIS, M.D., CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION

Mr. Chairman, and members of the Committee, I am pleased to be here to present the views of the Veterans Administration on S. 2514, the "Veterans' Administration Health Care Amendments of 1984"; S. 2210, a bill to revise and clarify the eligibility of certain disabled veterans for automobile adaptive equipment; S. 2269 and subsequent amendments, the "Veterans' Administration Health-Care Program Improvements Act of 1984"; and S. 2278, the proposed "Care for Chemically Dependent Veterans Act".

S. 2514

VA/COMMUNITY COORDINATION

S. 2514 contains five major provisions. First, it would require the VA to designate an office in each health-care facility and in the Central Office to coordinate and make arrangements for the provision of referral services to veterans in obtaining health-related services from non-VA sources available in the community. The VA favors the stated purpose of this provision to encourage greater coordination and use of private and non-Federal resources to assist veterans who need additional care following their discharge from VA facilities.

It is not clear that this provision provides VA any enhanced authority, although your comments in the Congressional Record express such an intension, Mr. Chairman.

The VA provides referral services which are already routinely furnished by various personnel including nurses and social workers at all VA medical centers. This is currently an activity which comes under the umbrella of the Information and Referral Program that is the subject of an Interagency Agreement. We see no need for legislation which would simply provide authority for ongoing activities.

DRUG AND ALCOHOL TREATMENT

Second, this bill would extend the VA's authority to provide contract care to veterans in halfway houses for alcohol or drug abuse disabilities and would mandate certain actions in the administration of the VA's care of veterans suffering such disabilities. We favor an extension of VA's authority under section 620A of title 38, United States Code, as provided for in section 5 of S. 2269 and in S. 2278. However, we favor a three-year extension of the program in order to allow periodic review of the program's effectiveness. Legislation will shortly be submitted proposing such an extension.

We object to the alcohol treatment and rehabilitation provisions of S. 2514 because of requirements which tend to prescribe in statute the manner in which VA should treat these disorders. For example, this provision rigidly limits halfway house treatment for each episode to 60 days. It is already our policy to review all cases at a 60-day point of length of stay, and limit further care based on an individual case review. The average length of stay for our contract halfway house program is 41 days. However, 12 percent of our patients do exceed 60 days based on their need for a longer period of care. The imposition of a 60-day limit on this program would jeopardize the clinical management of this significant number of cases.

Mr. Chairman, this section would also require the VA to promulgate regulations to govern the VA-operated programs for care of veterans for alcohol and drug dependence disorders. Regulations on the use of individualized treatment plans and on the maximum duration of care based on non-VA program averages would be mandated.

Perhaps the regulatory scheme as outlined would be appropriate as a basis for making third-party payment for such service. However, for a direct care provider it will interfere with the clinical management of the individual case. Obtaining valid non-VA wide averages for periods of such treatment is not possible at this time.

Mr. Chairman, we should point out that VA policies do address the apparent purposes of this provision. We have published a program guide which recommends procedures for establishing and operating these treatment programs. We have reporting mechanisms which permit us in Central Office to monitor program operations. Each VA medical center has Utilization Review and Quality Assurance Programs. Further, standards are also included in accreditation requirements of the Joint Commission on Accreditation of Hospitals.

Mr. Chairman, while we recognize that an effort has been made to reserve to VA discretion regarding the specific content of the proposed regulations, this section of the bill raises trouble-some questions. Thus, we do not believe that federal regulations are a necessary or appropriate vehicle for the establishment of medical policies. Likewise, we do not believe legislation is needed to realize improvements in lengths of stay and treatment planning in these programs. Accordingly, although we concur with the broad aims underlying this provision, we do not believe a statutory response is desirable and oppose section 3 of S. 2514.

DEVICES FOR THE DEAF

Section 4 of S. 2514 is apparently intended to authorize the VA to furnish any totally deaf veteran with a "telecaptioning television decoder" and other "devices for the hearing impaired." VA already has authority to furnish devices for the hearing impaired based on medical need. As such we believe this provision is unnecessary and do not favor its enactment. If section 4 is not simply a technical amendment, as described in the Congressional Record, but a provision that would seek to eliminate medical need as a basic criterion of eligibility for one group of veterans, we would oppose its enactment.

MANAGEMENT OF PTSD CARE

Section 5 of this bill would require the VA to establish a position of Associate Director for Post-Traumatic Stress Disorder (PTSD) in the Mental Health and Behavioral Sciences Services of the Department of Medicine and Surgery to develop policies, provide guidance, and coordinate services for Vietnam-era veterans with post-traumatic stress disorder, and to educate VA health-care personnel about PTSD. VA would also be required to establish a task force to develop a series of specified policies concerning PTSD care and research.

Mr. Chairman, the subject of VA care for Vietnam veterans suffering from PTSD is a dynamic area within VA. It is an area which is rapidly evolving and may have given rise to a perception that legislation is needed. We see no need for this legislation, however. Mr. Chairman, the VA has in recent years taken extraordinary new initiatives concerning the effects of PTSD not only on Vietnam veterans, but all combat veterans. This area is central to the mission of the agency.

A number of VA facilities have established PTSD inpatient units. Centrally directed staffing guidelines for such establishment and operation of dedicated PTSD inpatient units have been developed, and are presently under review.

Since the institution of the Vet Centers in late 1979, and the promulgation of an official diagnosis for the condition by the

American Psychiatric Association in 1980, recognition of PTSD and institution of effective services in Vet Centers and VA Mental Health Clinics have greatly increased.

In the VA Central Office, PTSD treatment is coordinated through our Psychiatry Service, which is in the Mental Health and Behavioral Sciences Service. Our Readjustment Counseling program also provides counseling assistance to many veterans suffering from PTSD. It is important to recognize that, unlike many other psychiatric conditions, post-traumatic stress disorder is one manifestation of a normal recovery process, in reaction to an external set of stressors. The disorder may present with widely varying degrees of severity, requiring widely differing types of psychiatric care, psychotherapy, and counseling. Given the complex nature of this disorder, we urge that you reconsider the proposal to mandate that VA establish a specific position that separates PTSD care from other aspects of psychiatry. This step would be contrary to good management practice. The delivery of PTSD care and education is being furnished effectively on the basis of close cooperation of several services--Mental Health, Social Work, and Readjustment Counseling, and the Office of Academic Affairs. We believe that an effort to create a statutory position, with over-arching responsibility within one element represents a poor management mechanism and an undesirable legislative precedent.

As regards what appears to be the major thrust of this provision, we submit that delivery of effective PTSD care is not simply a matter of developing centralized policies but perhaps more importantly a matter of continuing medical education. Such education efforts are a priority for us. Specialized education programs on diagnosis and care of PTSD have been and will continue to be offered under the auspices of our Regional Medical Education Centers, for example. We do not seek to minimize the importance of managing and coordinating PTSD care to the extent possible. We simply urge that the agency be permitted to focus its expertise in accordance with evolving needs as determined by the Chief Medical Director.

In essence, we do not believe that section 5 of S. 2514 is necessary or desirable. Accordingly, we do not support it.

REPORT ON "RESPITE CARE" AND CARE OF THE TERMINALLY ILL

Finally, S. 2514 would require the VA to submit a report by September 30, 1985, to both Veterans' Affairs Committees on programs to provide care to terminally ill veterans and their families and care for veterans for brief periods in order to provide a respite to veterans' families. We have no objection to reporting on care provided terminally ill patients.

S. 2269

VIETNAM ERA

S. 2269 contains 11 provisions relating to the VA health-care program.

First, we favor the provision which would revise the definition of the term "Vietnam era" to include the period from July 8, 1959 through August 4, 1964, if the veteran served in Vietnam during that time. The VA believes this is an appropriate change in the law. We estimate that approximately 48,000 veterans served in Vietnam between July 8, 1959, the date of the first American military casualty, and August 5, 1964, the date of the Gulf of Tonkin Resolution. Those veterans served under adverse conditions which can be considered akin to wartime conditions. It is reasonable that they be eligible to receive those benefits for which war time service, in general, and Vietnam-era service in particular, is a requirement.

Veterans covered by this provision would become potentially eligible for several benefits. Principally, they could receive nonservice-connected pension benefits if they also meet disability, income, and net worth requirements. Other benefits they might receive include certain burial benefits, readjustment counseling services, loan guaranty benefits in certain cases, and certain education, on the job-training, or apprenticeship benefits for the educationally disadvantaged, unskilled, or unemployed veterans. The number of veterans who would be affected and who are not otherwise eligible for these benefits is not large. Thus, the cost to provide these additional benefits would most likely not be significant in magnitude.

BEREAVEMENT COUNSELING

Section 3 of S. 2269 would authorize the VA to continue providing counseling or mental health services to family members for a period of up to six months following the veteran's death in cases where the veterans' family members had been receiving counseling or mental health services in connection with the veteran's care. Bereavement counseling for family members is an integral component of hospice care and would be beneficial to family members in many other cases. We believe that the six-month limitation is a reasonable time period for such counseling and consider this authority to be a necessary component of any hospice care program. Therefore, we support this provision. We anticipate that enactment of this proposal would not result in significant additional costs.

READJUSTMENT COUNSELING SERVICES

Section 4 of this bill would authorize the VA to provide readjustment counseling to (1) persons still on active duty with the Armed Services who served during the Vietnam era, and (2) to those who served in the Armed Services after the Vietnam era in combat situations. We believe our readjustment counseling program has been an effective one, and one which could benefit active duty personnel who served in Vietnam as well as in combat areas such as Grenada and Lebanon.

In that connection, we would support an amendment to section 612A to extend eligibility for such services to those veterans who served on active duty during a period after May 7, 1975 in an area in which hostilities occurred. We see no need, however, for extending such eligibility to active duty members. VA would welcome the opportunity to provide such needed services to active duty personnel pursuant to "sharing" agreements authorized by Public Law 97-174. As there already exists a vehicle for providing these unique VA health care services to active duty personnel, albeit subject to DoD reimbursement for those services, we do not favor enactment of that facet of section 4.

HALFWAY HOUSE CARE

We strongly favor section 5, which would extend VA's authority to contract in the community for halfway house treatment and rehabilitation for alcohol and drug dependence or abuse disabilities. However, as I mentioned before, we favor a three-year extension of this program so that periodic reviews of the program could occur. Legislation will be submitted in the next few days proposing such an extension. This program was authorized on a pilot basis by Public Law 96-22 and was begun in FY 1980. Our evaluation of this program has shown that it provides an important option for treatment of certain cases of substance abuse which require care beyond existing VA hospital alcohol and drug unit capabilities. VA's study of this pilot program as described in a report which we will shortly be submitting to Congress under Public Law 96-22 demonstrates the considerable benefits of outplacement of such patients into this modality of treatment.

VA SECURITY SERVICES

Section 6 of S. 2269, as amended by Amendment No. 2850, is intended to enhance VA security operations on land and buildings within the jurisdiction of the VA not under the control of the Administrator of General Services. It would accomplish this by clarifying the authority of Veterans Administration police officers, by increasing the uniform allowance payable to such officers and by authorizing the Administrator to pay increased rates of basic pay when necessary to recruit or retain quality personnel as VA police officers.

In general the VA favors section 6. However, throughout section 6 the titles "protective services personnel" and "protective services officers" are used. The Veterans Administration employs several categories of personnel other than police officers whose duties are protective in nature. These include firefighters, safety specialists, and fire protection inspectors. We do not believe these employees were intended to be or ought to be within the scope of the proposed amendments. Section 6 should be amended to refer to "Security Service personnel" and "Security Service officers."

Proposed section 218(a)(1) provides that the Administrator shall prescribe regulations for the maintenance of law and order and the protection of persons and property on VA property. These regulations are to include penalties for violations of such regulations, the authority of VA police officers to enforce laws and regulation and to make arrests, the training requirements for VA police officers and rules limiting the carrying and use of weapons by VA police officers. Current regulations already effect these requirements. However, under this proposed amendment the Administrator would be required to obtain the concurrence of the Attorney General in these regulations. The Veterans Administration has no objection to this requirement. We believe that such issues are extremely important to the conduct of Government law enforcement efforts in general and should be coordinated on a Government-wide basis. Notwithstanding our support for Attorney General review there would obviously be some time lag between the enactment of this bill and the effective date of promulgation of the required regulations, and are concerned that during the interim this statute would have the effect of repealing or negating the current regulations. Some language addressing this problem should be included in the bill. Additionally, as a technical matter we recommend that the proposed section 218(a)(1)(A) be further amended to delete the words "law and" since the provision is intended to give authority to prescribe penalties only for violation of regulations.

Section 218(a)(2) as proposed in the bill would increase the maximum penalty for violating VA law enforcement regulations. The maximum fine would go from $50 to $500 and the maximum jail sentence from 30 days to 6 months. The change would allow the Federal courts to make the punishment more appropriately fit the crime and would bring

VA penalties into line with the limits for petty offenses as defined in title 18, United States Code, as well as those currently available under the law enforcement regulations of other agencies.

More importantly, the change would increase the likelihood of these cases being prosecuted and would make these petty offense regulations a more effective deterrent. The current limits of $50 and 30 days are so insubstantial that they lack deterrent effect and tend not to justify the efforts and cost in resources that are involved in prosecuting them.

Another obstacle to effectively deterring criminal conduct on VA property has been the question raised about whether section 218, as currently worded, gives the VA police officers enforcement and arrest authority with respect to misdemeanor and petty offenses, such as enforcement of current regulations. As an additional technical matter, we recommend that section 218(b) be further amended to clarify that VA officers' arrest authority is limited to VA property or arrests which are made in "hot pursuit" of a suspect leaving VA property.

Subsection 218(b), as recast by the bill, would clarify the authority of VA police officers to enforce laws and regulations and to make arrests. This would be in addition to VA's current felony enforcement authority. We favor this provision as a way of removing any doubt and further enhancing the deterrent effect of the statute and regulations.

For some years, one of VA's major concerns has been to improve recruitment and retention of highly qualified personnel to serve as VA police officers. The VA has long had difficulties with such recruitment and retention, especially in certain geographic areas. Current authorities have proven inadequate to deal with many of the problem areas.

One source of recruiting/retention problems is the low morale and financial hardship resulting from the fact that required uniforms cost much more than the authorized uniform allowance provides. Currently, VA police officers are allowed a flat $125 annually. Under subsection 218(d), as proposed in the bill, they would be authorized a one-time uniform purchase allowance of up to $400 and an annual uniform purchase allowance of $200 thereafter. We strongly support this measure. It would help rectify the unfair financial hardship currently faced by VA police officers. In our view, no one should have to suffer a financial disadvantage in order to work as a VA police officer, and the uniform allowance provisions would help prevent that.

The principal problem in the recruitment and retention of highly qualified personnel is our inability to pay competitive rates, particularly in certain geographic areas. This is evidenced by relatively high officer turnover in areas where competitive pay rates are generally higher than we were able to pay. The bill proposes to resolve this problem by amending subsection 4107(g) of title 38 to allow the Administrator to authorize increased minimum, intermediate or maximum rates of basic pay on a nationwide, local or other geographic basis when he determines that it is necessary in order to recruit/retain the services of highly qualified police officers. We strongly support this provision. It provides a flexible, efficient means to deal with the pay disadvantage that exists in certain markets--a capability to target special pay rates where they would do the most good in recruiting and keeping law enforcement personnel. However, we believe that this amendment should be limited to a three-year period.

COMPTROLLER GENERAL

We defer to the views of the General Accounting Office on section 7, which would modify the due date of a recurring Comptroller General's report on compliance by the Office of Management and Budget with requirements relating to funded personnel ceilings in the Department of Medicine and Surgery.

STATE HOMES

Section 8 of the bill would amend our state home facility grant authority. This provision would require the VA to assign a priority for each application for a state home grant according to criteria to be prescribed in regulation if funds appropriated for any fiscal year for state home grants are not sufficient to make all the grants requested of the VA for that fiscal year. The VA would be required to approve grants according to their priority.

This program currently operates under a system which funds grants based on the order in which "approvable" applications are submitted. The current method of prioritizing grant applications is understood and accepted. We are not aware of any state home facility that has been constructed with VA grant assistance that was not needed. Thus, we see no need for legislative action. While we understand the rationale underlying this proposal, we are concerned that, on balance, such a change in policy would have an adverse effect on a sound, established program. Thus, we envision that implementation of the proposed policy would engender considerable controversy about decisions concerning relative priorities among proposed State projects. Based on these concerns, we oppose enactment of this section.

CONTRACT CARE

We will be proposing legislation in the next days to extend the VA's authority to provide care on a contract basis to eligible veterans in Puerto Rico and the Virgin Islands for three additional years, through September 30, 1987. This authority expires on September 30, 1984. This extension is needed in order that these veterans may continue to receive ongoing care while other more desirable alternatives are developed. We therefore request that section 10 of S. 2269 as amended be changed to provide for a three-year rather than a one-year, extension of the contract authority.

NATIONAL PTSD CENTER

Finally, section 12 of S. 2269 would mandate that the VA establish a national center for research into post-traumatic stress disorder (PTSD) and for training VA health-care personnel on appropriate treatment for veterans with this disorder. The VA would also be required to report within 90 days of the bill's enactment on efforts to establish the center and provide an assessment and report on its ability and capability to diagnose and treat veterans suffering from PTSD. We consider the effective care and treatment of PTSD, as well as efforts to expand the understanding of health-care professionals regarding the diagnosis and treatment of the disorder, to be critically important aspects of the VA's responsibilities. Therefore we support the objective of this provision. In fact, we are encouraging the development of PTSD programs at our VA medical centers. As discussed previously, we do not believe there is any need to enact this provision since VA already has broad statutory authority to achieve its purposes. Accordingly, we do not favor enactment of this provision.

S. 2210

Section 1902 of title 38, United States Code, authorizes VA to provide automobile adaptive equipment to certain veterans and servicepersons who suffer from severe service-incurred disabilities to enable them to safely operate an automobile or other conveyance. Currently, under 38 U.S.C. § 1903(c), VA may not provide an eligible person adaptive equipment for more than one automobile or other conveyance at any one time. Thus, a veteran who has transferred title to an adaptive vehicle but continues to have the use of that vehicle would not be eligible for VA reimbursement for adaptive equipment on a new vehicle. But currently there is no statutory limitation on how frequently such persons may purchase a new vehicle and obtain new adaptive equipment at VA expense. S. 2210 would remove the bar to transferability and impose a limitation on the frequency with which the VA would reimburse a veteran for adaptive equipment. VA's current policy permits reimbursement for adaptive equipment on up to three vehicles in two years. S. 2210 would amend section 1903(c) to provide that an eligible person may not be provided adaptive equipment for more than one automobile or other conveyance in a three-year period except when exigent circumstances justify early vehicle replacement.

In commenting on this provision, we would stress that very few veterans seek reimbursement for adaptive equipment from the VA on so frequent a basis that it could be termed "abusive." We estimate that most of the eligible veterans do not seek reimbursement more than once in a three-year period, with the average utilization for the last three fiscal years being approximately one vehicle each 6.4 years. Moreover, it is important to note that many of the veterans who trade vehicles more frequently are severely disabled and feel the need for extremely dependable transportation because of the severity of their disabilities.

Nevertheless audits and program evaluations have revealed a few instances where veterans have sought reimbursement for adaptive equipment more frequently than may have been essential. Some of the previously existing excesses in program utilization have already been corrected with the issuance of a DM&S circular, providing guidelines with respect to the administration of the adaptive equipment program. However, in light of the potential for abuse that may still exist in this program, we have no objection to the enactment of legislation to establish more restrictive guidelines. We strongly recommend, however, that a one-vehicle-in-two-year rather than a one-vehicle-in-three-year restriction would be more feasible. Such a limitation would be somewhat more restrictive than our current guidelines, but would still allow reimbursement on a frequent enough basis to assure dependability in the vehicles used by these extremely handicapped veterans. Even such a restriction, however, would need a provision whereby the Administrator could make exceptions under specific factual circumstances, where true need exists.

We estimate that the annual cost savings would be minimal.

Mr. Chairman, that concludes my statement. I would be pleased to respond to any questions you, or any other member of the Committee, may have.

Chairman **Simpson**. Senator Cranston has a conflict in his schedule and so I am going to let him proceed with questions at this time.

Al.

Senator **Cranston**. Thank you very much. I appreciate that very greatly.

Don, as I noted in my opening remarks, I greatly appreciate the VA's strong support for many of the provisions in S. 2269 as amended.

On page 10 of your statement, Don, you indicate that you do not favor enactment of the provisions in S. 2269 that would extend readjustment counseling eligibility to individuals on active duty, but that you would be prepared to provide readjustment counseling to such personnel under sharing agreements authorized by Public Law 97-174.

Is your primary concern in this regard the cost of providing such services or your view that the Defense Department should bear the cost of such services for active duty personnel?

Dr. **Custis**. I think the answer, Senator Cranston, is "yes" to both of those questions. I would say that accompanying the concern regarding dollar reimbursement is also a concern regarding our current manpower. We are not keeping up with our veteran's need for care at the present time.

I might also take the opportunity to say that I am currently sitting on the advisory counsel in the Office of Naval Research where this question was discussed. In my contribution to our report to the Secretary of the Navy, who has charged us with evaluating the quality of Navy combat contingency status, I have inserted a recommendation that military medicine recognize the importance of early intervention in the case of PTSD and the development of the ability in-house in the military for early treatment of this disorder.

Senator **Cranston**. Would you please get a copy of that report to Chairman Simpson and to me as soon as you can?

Dr. **Custis**. I am not sure that I can.

Senator **Cranston**. If you can, please try.

Dr. **Custis**. In principle, we are in favor of it. We would like to work with the Navy staff in modifying language in the report.

Senator **Cranston**. Are you aware of any requests for sharing or readjustment counseling services having been made by DOD entities either to Vet Centers or VA medical centers since the enactment of Public Law 97-174?

Dr. **Custis**. I know for sure there have been no such sharing agreements.

Senator **Cranston**. With reference to entering into such sharing agreements, The American Legion makes a very good point in their testimony that I think you need to consider. On pages 14 and 15 of its statement, the Legion suggests that were DOD to offer readjustment counseling services directly, many career personnel would not seek such assistance for fear of jeopardizing their advancement because of receiving what could be construed as psychiatric treatment. Although this concern would be addressed if VA provided these services in the way I have proposed, if it did so pursuant to Public Law 97-174 that would require that the service person be referred to the VA by DOD and this could create the very problems the Legion has raised.

Would you agree that this concern about taint is a legitimate one that we should try to address?

Dr. CUSTIS. May I defer to my psychiatrist friend, Dr. Brown, to my left?

Senator CRANSTON. Yes.

Dr. BROWN. Senator, I think that is a real concern and it is something that I think should be looked at in order to see if we can do anything to avoid that taint.

Senator CRANSTON. Thank you very much.

Dr. CUSTIS. I am mindful, when alcohol was recognized as a disease in the military that this taint was a real problem. I think it is true today that this has totally disappeared. The same thing might well be true in regards to readjustment counseling.

Senator CRANSTON. I hope it will and it would be great if it did, but it has not yet.

One way this referral problem could be avoided would be for the DOD and VA to enter into a national level agreement pursuant to which the VA would provide readjustment counseling to eligible active duty personnel, but without the need for a referral from DOD and DOD in turn would reimburse the VA based on an aggregate number of visits without the names of those receiving such assistance being specified.

Of course, to make such an agreement possible, we would need to amend the law to permit an exception to the referral requirement where both agencies wished to waive it.

Would you support such an approach and do you believe DOD would perhaps likewise on a 1-year experimental level?

Dr. CUSTIS. That would mean Congress would support it. Again, I think that if that should happen, my final concern would be the matter of resources.

Senator CRANSTON. There is no indication that you would be overwhelmed by active duty people seeking such help. Would you support—could you discuss this with the Defense Department and report back promptly?

Dr. CUSTIS. Yes, sir.

Senator CRANSTON. Thanks.

[Subsequently, the Veterans' Administration submitted the following information:]

The Department of Defense appears reluctant to enter into a national sharing agreement in which the VA would provide readjustment counseling to eligible active duty personnel with DOD having no knowledge of who is availing themselves of VA services. The medical record of an individual on active duty is felt to be essential knowledge of command. In addition, many individuals on active duty have security clearances. Complete knowledge of these individuals' background is critical. Thus, in all likelihood, DOD would oppose waiving the referral requirement in the VA/DOD Sharing Law for the VA to provide readjustment counseling for active duty personnel.

Senator CRANSTON. If such a national agreement were established please describe for the record how you would work with DOD to publicize the availability of VA counseling services and to encourage active duty personnel who could benefit from such services to take advantage of them.

Dr. CUSTIS. We will supply that for the record.

[Subsequently, the Veterans' Administration submitted the following information:]

With DOD consent, posters advising active duty personnel of access to VA readjustment counseling could be placed in all military treatment facilities if an agreement is worked out.

Senator CRANSTON. Don, section 11 of S. 2269, as proposed by amendment No. 2850, would amend section 618 of title 38 to provide that income earned by veterans participating in VA's rehabilitative incentive therapy and compensated work therapy programs would be excluded in computing their income for VA pension program purposes.

In your personal professional judgment, if veterans who are or should be in incentive therapy or compensated work therapy programs refuse to complete such a course of therapy because of the pension disincentive, what would be the likely result in terms of their need for further hospital or outpatient care?

Dr. CUSTIS. It would be my personal opinion, Senator, that if, what we know to be a very effective rehabilitation program were crippled by the disincentive that is implied here, it would indeed result in a reversion of dependence on more medical care.

Senator CRANSTON. From the standpoint of the therapeutic value of these programs and the potential impact of the recent VA actions to count income received under these programs for pension program purposes, what is your personal professional view on whether or not such income should be counted for pension purposes?

Dr. CUSTIS. I think it is a significant disincentive of the purpose of the program, mainly, rehabilitation, were this to be counted as part of the pension program.

Senator CRANSTON. Don, in light of the statement in your February 22 letter to me that "There is less than unanimity among VA psychiatric staff as to the desirability of PTSD inpatient units," I was quite surprised to see your statement on page 17 that the VA is encouraging the development of PTSD programs at VA medical centers.

As you know, I wrote to you on March 23 seeking further information on the overall issue of the VA's efforts on PTSD and I will wait for your response to that letter to get a more complete picture of what is going on. However, I would appreciate it if briefly now, and in more detail for the record, you could describe what steps are underway at present to encourage the establishment of PTSD units and what success you are having as a result of these efforts.

Dr. CUSTIS. I would like to start the answer to that question, Senator, and then defer to Dr. Brown. I think there is a need to clarify that our reluctance has to do with the dictation of the modality of treatment. There is indeed a difference of opinion on how best to handle PTSD. There is also wide variation in the severity of this disorder and, therefore, the need for a variety of treatment modalities.

I will ask Dr. Brown to describe what we are doing in the way of establishing criteria for those hospitals who have the resources and who feel they can properly staff these units and to what extent we will encourage the expansion of this program.

Dr. **Brown**. Senator, there are a number of things we are doing to encourage it. One is, as Dr. Custis has said, disseminating to the field guidance for the MEDIPP submissions. Specific guidance is being issued to the effect that each district will review the need for treatment of post-traumatic-stress disorder and will incorporate that into their district plan. That is one item.

Another is that Dr. Custis is encouraging the establishment of a new PTSD center in Cleveland, which will be tasked not only to provide treatment but also to evaluate various modes of treatment, to do research, and to disseminate what they learn through education through the RMEC's and other educational processes.

Another effort is to try to educate as many people as possible within and without the VA and there are quite a number of people who are active in this effort.

Senator **Cranston**. What resources are you putting into promoting that center?

Dr. **Brown**. Into Cleveland?

Senator **Cranston**. Yes.

Dr. **Brown**. Their request is being considered now and that decision has not been made as yet.

Senator **Cranston**. When will that be made?

Dr. **Custis**. I think we should tell you, Senator, that their request exceeds our ability to provide support in this fiscal year. Parenthetically, you might also be interested to know that we have already selected a director of that center and he is present with us in the room.

Senator **Cranston**. Do you intend to give them some additional resources?

Dr. **Custis**. We will do everything we can to support that program. I think we will be in, hopefully, in a better position to do so in the next fiscal year.

Senator **Cranston**. Let us know what you do and when you do it. I would appreciate it.

[Subsequently, the Veterans' Administration submitted the following information:]

An active process of discussion is underway with the medical center concerning the proposed scope of activities. The outcome of these discussions and available resources will determine the final resource commitment to this effort.

Senator **Cranston**. Al, I think my time is up and I thank you very, very much.

Chairman **Simpson**. Thank you, Al, for your participation and your assistance to me on this committee. I deeply appreciate it.

I have some questions now that I would like to proceed with and then we will go to Senator Mitchell. You state that social work departments at VA hospitals as part of their discharge planning duties develop ties to community sources of health care. Has any VA medical facility or district administratively experienced or initiated any kind of systemmatic network of community sources of care other than just contacts made by individual social workers or volunteers? Have any types of these efforts been placed on a computer or set up in a systemmatic way?

Dr. **Custis**. The report that we are submitting for the record gives some of the specifics to answer your question, Mr. Chairman.

[Subsequently, the Veterans' Administration submitted the following information:]

COORDINATION OF VA/COMMUNITY SERVICES

The VA health care system has an established program which accesses, integrates and utilized the broad range of community health and welfare resources to meet the needs of the full range of chronically ill and/or functionally impaired veterans. Through a wide range of community coordination and development activities, Social Work Service provides community information, referral, placement, and follow-up services to ensure the integration and support of family and community resources in the treatment, rehabilitation and continued care patients. Active participation by social workers in area health and welfare councils has developed effective referral networks, expanded knowledge and use of community resources and contributed to development of resources to fill gaps in the established community service network.

At each VA medical center, Social Work Service provides a focal point of contact between the VA health care system, the veteran, his family and the network of community services and resources. This includes a broad range of community development, information, referral, placement, and follow-up services provided to patients of all ages and diagnostic categories. Community resource information and directories have been developed which cover all medical and social agencies/resources within each primary VA medical center services area relevant to the needs of veterans and their families. These materials/resources are utilized by social workers and other health care personnel in providing treatment, discharge planning and aftercare services to patients within all inpatient, ambulatory and extended care programs.

Community health and social support services necessary and frequently utilized in the treatment and rehabilitation of our veteran patients are identified in Attachment A. Attachment B identifies points within the VA medical care system at which veterans are identified and referred to community health and social support services. Significant utilization of the community resource network is reflected in the following services provided by Social Work Service during FY 83:

Referrals of Veterans from VAMC's to Community Resources:

1. Community Agencies/Services	144,021
2. Other Government Programs	114,458
Total Referrals	258,479

Social Work Assisted Placement of Patients Treated by VAMC's:

1. Contract Nursing Home Care	26,007
2. Non-VA Paid Nursing Home Care	7,638
3. Halfway Houses	4,943
4. Residential Care Homes	6,708
5. Own Home	136,409
6. Other Community Placements	43,433
Total Placements	225,138

The following are examples of specific actions taken by DM&S to further develop, utilize and coordinate services with the community:

- Social Work has provided linkage with and participation on community health and welfare planning councils, as well as community planning groups for specific diagnostically related groups (Mental Health, Substance Abuse, Spinal Cord Injury, Visually Impaired, Dialysis).

- Social Work staff perform over 900,000 miles of authorized community travel quarterly in the provision of discharge planning, outpatient treatment and follow-up services and the full range of community planning and service integration.

- Specific focus and services in relationship to aging veterans have been provided through Information and Referral (I&R) services in concert with Administration on Aging (AoA) and other agencies since 1973.

- During FY 83, 115 VA medical centers reported ongoing continued contact with Area Agency on Aging (AAA) staff to improve coordination of services and exchange of program information. Eighty-six reported specific joint program or resource development activities with AAAs, and 32 reported joint conference or training activities with AAAs.

- During the last six months of FY 83, 1,947 VA volunteers were utilized in community assignments and contributed a total of approximately 75,000 hours of service.

- Through joint efforts with the National Health Screening Council for Voluntary Organizations, 14 VA health care facilities have reported participation in community health fairs. Planning is in process to increase VA's participation with NHSCVO and the private sector in promoting health awareness and prevention.

- VA's Residential Care Program has facilitated the transition of literally thousands of psychiatrically disabled and socially at-risk veterans from hospital to the community. This nationwide program (over 3,000 homes with approximate ADC of 12,000) has demonstrated theraputic and cost effective value has potential for expansion to the aging, medical and socially at-risk patient.

COMMUNITY SERVICES AND RESOURCES
UTILIZED BY THE VA HEALTH CARE SYSTEM

HEALTH SERVICES

Medical Care
Mental Health Services
Nursing Home Care
Visiting Nurse
Home Health Aide
Hospice
Respite
Adult Day Health Care
Hospital Based Home Care

FINANCIAL RESOURCES

VA Compensation
VA Pension/A&A/Housebound
 Benefits
Social Security
Supplemental Security Income
Medicare
Medicaid
General Assistance (States)

HOUSING

Congregate Housing
Independent Living
Community Residential Care
HUD-Assisted Housing
Board and Care

NUTRITION

Congregate Meals
Meals-on-Wheels

PERSONAL ASSISTANCE

Personal Care
Homemaker Services
Chore/Home Repair Services
Shopping
Transportation
Legal/Protective

SOCIAL/RECREATIONAL SERVICES

Geriatric Day Care
Senior Citizen Centers
Companion Program
Friendly Visiting

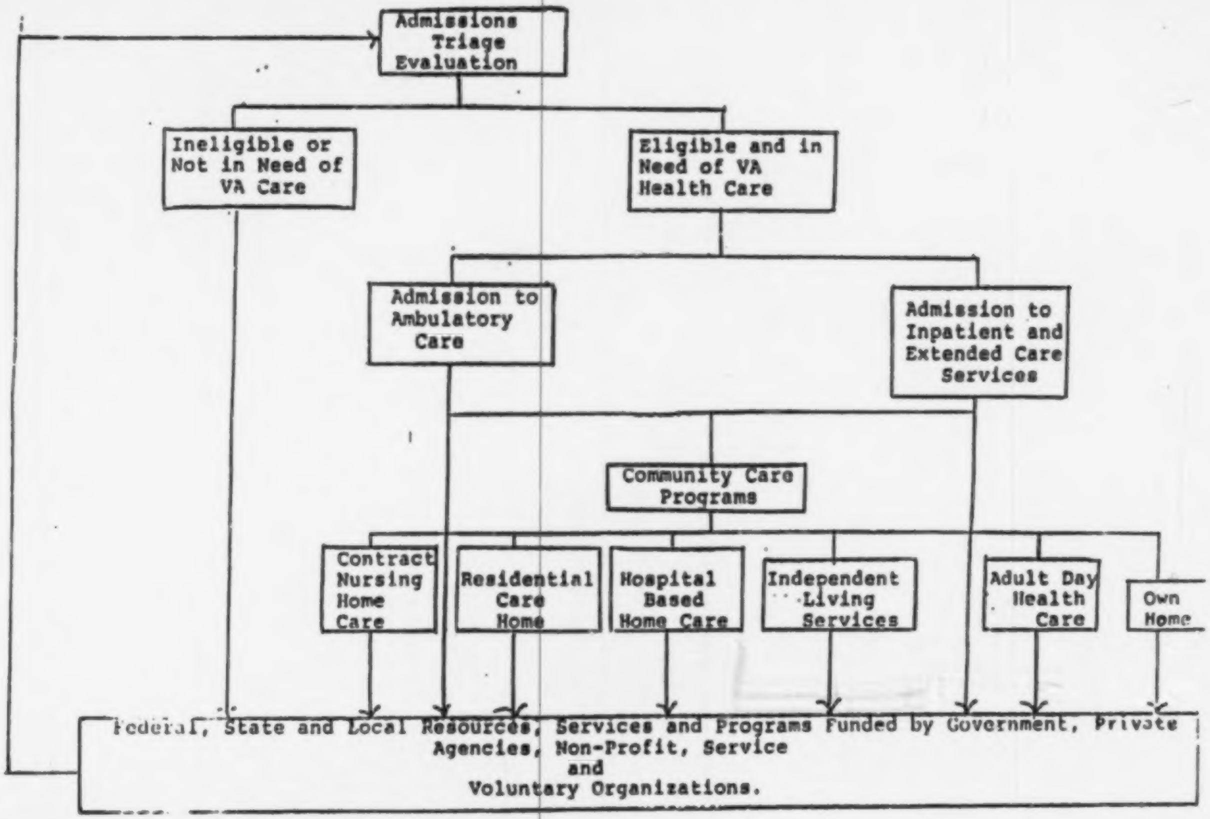
INFORMAL SUPPORT NETWORK

Family
Friends
Neighbors
Church
Fraternal Organization
Veterans Service Organization
Volunteers

INFORMATION AND REFERRAL

Area Agenices on Aging (AAA)
Community Resource Directories

POINTS OF REFERRAL TO COMMUNITY HEALTH AND SOCIAL SUPPORT SERVICES IN THE VA HEALTH CARE SYSTEM


Admissions Triage Evaluation
Ineligible or Not in Need of VA Care
Eligible and in Need of VA Health Care
Admission to Ambulatory Care
Admission to Inpatient and Extended Care Services
Community Care Programs
Contract Nursing Home Care
Residential Care Home
Hospital Based Home Care
Independent Living Services
Adult Day Health Care
Own Home
Federal, State and Local Resources, Services and Programs Funded by Government, Private Agencies, Non-Profit, Service and Voluntary Organizations.

Information & Referral Services also provided to veterans referred to Social Work Service by DVB and Readjustment Counseling staff, community agencies and self-referrals.

Dr. CUSTIS. I would also ask the director of our social work service, Mr. John Fulton, to respond to your question.

Mr. FULTON. Good morning. At each of the VA medical centers in the country, there is a social work department whose responsibilities in patient treatment include discharge planning and development of linkages with the community that will enable the placement of patients into the community following their hospital care.

VA social workers participate in joint planning activities with the community health and welfare councils in each of the areas within which our hospitals are located. In terms of what is actually going on at the moment, as an example, our medical center in Tampa, FL, is very much involved with the community health and welfare agencies and is jointly developing a computerized approach to community resource information.

Chairman SIMPSON. Do all hospitals do that?

Mr. FULTON. All hospitals are working with their individual communities. I cannot say that every hospital is in the process of developing a computerized system, but each medical center has a system of exchanging information with other agencies and we have at each medical center a complete directory of community resources and referral information.

In some areas of the country we have had an opportunity to be, I think, fairly aggressive in helping to focus on the needs and develop resources.

Chairman SIMPSON. I understand what you are saying about individual needs and referrals based upon individuals, but I am talking about the aggregate, providing a way for the VA to consider referrals in terms of aggregate needs for the veteran population. Is that being pursued?

Mr. FULTON. We do have reports regarding numbers of referrals and types of placements and so forth by community areas. The medical center's involvement in their local area varies across the country in terms of the community agencies there are to work with them and the resources that are available.

In some areas, we have staff employed in this function full time. In California, for example, we have a social worker deployed full time to work with community agencies in developing the range of services and networks necessary to meet the community-based long-term care needs of veterans as well as residents of the larger communities.

Chairman SIMPSON. Let me ask another question and then I am going to ask Senator Thurmond if he has any statement he might wish to make.

In your testimony you seem to look rather dimly upon the approach which would provide a standard to the promulgation of regulations, which would fairly set out the intent and scope of alcohol treatment within the VA. And I think it is obvious there is a huge number of veterans who serve with alcoholic rehabilitation programs and various approaches. In the absence of regulations, how do you effectively provide specific guidelines and transmit information to the individual medical centers on new programs, initiatives for alcohol treatment?

Dr. CUSTIS. I would like to ask Mr. Fulton, in response to your question, to give some description of our interface with the AAA, and elaborate the quantity of our information referral activities and the number of veterans served each year. It is really a very ambitious program, Mr. Chairman.

[Subsequently, the Veterans' Administration submitted the following information:]

Individual medical centers are provided specific guidelines and information on new programs and initiatives for alcoholism treatment in a number of ways. An alcoholism program guide has been prepared and distributed to all VA health-care facilities. This guideline provides descriptions of contemporary practices in both treatment and program management. A number of circulars have been issued which instruct individual medical centers on how to obtain contracting authority and budget support for the non-VA, community-based, halfway house contract program. These circulars also instruct those participating medical centers in methods for accounting, and reporting periodically, their experiences with the new halfway house contract program. Another communication pathway which is particularly effective is that of periodic training conferences, sponsored by VA Central Office program staff, which bring together the key staff of individual medical centers and provide information on current trends in research, treatment, and program evaluation methods in the field of alcoholism. These training conferences have an additional virtue, that of providing opportunity for local alcoholism program initiatives to be shared and critiqued by professional peers assigned to other programs. Finally, a number of professional services letters are prepared in Central Office and distributed to all VA medical centers, which describe and discuss important trends in the field. In this regard, such a professional services letter was issued last month, which called for specific attention to all admissions to VA medical centers in regard to the possible presence of an alcohol abuse problem, in addition to the principal cause for admission. The medical centers were encouraged to collaborate with Central Office program staff in the development of on-site skills for this added task.

Mr. FULTON. In our work nationwide with the communities around each of the medical centers, our staff have focused on working with community resources that were appropriate to the needs of the specific patient populations. We have worked very closely through the sixties and into the seventies with community-based mental health resources and placed literally thousands of long-term psychiatric patients into the community.

In recent years, we have focused specifically on the needs of such groups as spinal cord injured patients and have established at each medical center a specialist to integrate VA and community services for these patients.

In the last 2 years, in particular, we have focused on increasing our activities with the Area Agencies on Aging—AAA's—in the local communities so that we could work more closely together in developing that service network that the older veteran and aging members of the larger communities are in critical need of.

Last year, our staff worked on a continuing basis with 111 AAA's. We had joint program development projects under way with 86 of them and we worked cooperatively with 32 in developing joint conferences and training activities.

In terms of our community referral network, during fiscal year 1983 we made 258,479 referrals to community health and social agencies in developing discharge and after care plans for veterans and we were involved in the placement of 225,000 patients in community residential and nursing home resources.

Chairman SIMPSON. Thank you very much.

Senator Thurmond.

Senator **THURMOND**. Thank you, Mr. Chairman, very much. It is a pleasure to be here today to hear the testimony on pending legislation relating to the health care provided to veterans.

I want to commend you, Mr. Chairman, for your many fine efforts on behalf of veterans since becoming chairman of this committee. Our Nation's veterans benefit greatly from your service and excellent leadership.

Mr. Chairman, S. 2514, which you introduced, and S. 2269, introduced by the ranking minority member, both of which will be discussed today, contain provisions that will make significant improvements in current health-care programs for veterans. I am especially supportive of the provision in S. 2514 that would improve the care provided veterans suffering from post-traumatic-stress disorder, known as PTSD, through establishment of an Associate Director for PTSD. Establishment of this position is necessary to clarify policy, provide guidance and coordinate care for veterans with this service-connected disorder.

I am also pleased that S. 2514 contains a provision which requires the VA to report to Congress on the various kinds of care that are available for the terminally and the chronically ill. Mr. Chairman, I believe it is highly appropriate that we explore compassionate alternative means of providing care for terminally ill veterans, especially at a time when many of our Nation's veterans are reaching the age of 65 and above.

Mr. Chairman, I look forward to the testimony that we will receive today regarding Senator Cranston's proposal concerning veteran patients involved in rehabilitation therapy programs, such as sheltered workshops. I have another engagement and have to leave, but I would be interested in this matter. As you know, current law requires that the income that is earned in these programs, however small, be counted as income for the purpose of calculating veterans' pensions. These are very special programs, which can assist the disabled to return to productive employment, and I believe careful consideration should be given to exempting at least a portion of this income in calculating pension benefits.

So, Mr. Chairman, I welcome the many distinguished witnesses here today who are testifying and I look forward to reading their testimony. As I stated, I want to thank you very much.

Chairman **SIMPSON**. Thank you, Strom, very much. I always appreciate your remarkable support in this committee and the Judiciary Committee. I have been very pleased indeed. Thank you.

Senator **THURMOND**. I have a few questions that I will submit for the record.

Chairman **SIMPSON**. Indeed. Senator Mitchell.

Senator **MITCHELL**. Thank you, Mr. Chairman. Dr. Brown and Dr. Custis, you will recall, I believe, the hearing last July in which we discussed the problem of health-care services for veterans living in rural areas. At that hearing, it was made clear through statistics developed in Maine what commonsense would have indicated to us anyway; there is a direct correlation between the distance from a veteran's residence to the nearest VA facility and the frequency with which that veteran receives health-care services.

In Maine, it was a reduction of as much as 75 percent utilization for those living the furthest distance. At that time, I asked you and

I asked in writing again following the hearing about national statistics to establish this as a national problem and you indicated that there are no national statistics on this basis. I would like to ask, do you not agree that the availability of such statistics would be valuable to the VA in evaluating the availability of services to veterans based upon where they happen to live and also to this committee in making the determination as to what we should do?

Dr. CUSTIS. Yes, Senator, I would agree that would be at least an interesting set of data. I am not at all sure that it would be that important to us compared to other determinants for what we should do.

I would like to take the opportunity to assure you, Senator, that we are not opposed to outreach programs and satellite clinics whether they take the form of a medivan or a team flying to a certain area. As you know, we have two such prototype programs in operation now.

Senator MITCHELL. I am going to get to that.

Dr. CUSTIS. We are also in the context of the strategic plan for the aging veteran, which will be released shortly and which I am sure will precipitate debate and concern as to how these individuals' non-institutionalized needs are going to be met. These needs certainly include satellite clinics that will come into very heavy study and consideration.

It is, in part, our desire to wait for that debate and wait for the aging plan to be considered by the Congress before we make any radical change—the substitution of in-house capability for our programs.

Senator MITCHELL. As I indicated in my question, the figures are clear and dramatic as to Maine. That the further a veteran lives away from the VA facility, the less utilization of health-care services is obtained by that veteran. The question was do you agree that such figures nationally would be useful to this committee and the VA? And I take it that your answer is "yes." Do you agree that they would be useful in evaluating this problem?

Dr. CUSTIS. I think it would be useful and interesting, but if it were to lead us to a VA presence literally in all rural communities in the country, I do not think the resources are available.

Senator MITCHELL. No one has suggested that. You are establishing a strawman there and no one has suggested there be a VA present literally in every rural community in America. That is a very different thing from what anyone has ever suggested.

The question is—the problem is clear, that veterans who live in rural areas do not have access, for a variety of reasons, on the same level as those veterans who live in urban areas or close by a VA facility. No one is suggesting, and certainly not me, that we put a VA facility in every rural community in America. But that is a problem that must be addressed.

Dr. CUSTIS. What other purpose would that serve, except to become a determinant as to whether or not we should place a satellite clinic in a rural area?

Senator MITCHELL. In some rural areas, but not in every rural community in America. You must first define the problem. And then you define a reasonable way to address it consistent with your resources. But it is not necessary to argue, because there is this problem the only answer therefore is to establish a VA presence in every rural community in America.

Dr. CUSTIS. Our answer to the problem today is the fee-basis program.

Senator MITCHELL. That is not a complete answer. We heard testimony last year about the clinics in Utah. Now, we spent a lot of time discussing the question of what is or is not, a clinic; what is, or is not, a facility; what is, or is not, a contract basis for service. But it is clear, is it not, in Utah, that in the communities of Roosevelt and Richmond, with populations of 4,800 and 6,000, clinics have been established and funded this year at a cost of a half million dollars?

Dr. CUSTIS. As a prototype project.

Senator MITCHELL. Have you been able to evaluate any of the results of those clinics?

Dr. CUSTIS. Yes. We are very pleased with them and they are being considered for extension in the context of aging veterans and the additional requirements that those needs will impose on us.

Senator MITCHELL. Could you provide me please with some detail on what form that consideration is taking? Do you have some internal evaluation of that?

Dr. CUSTIS. We can in the proper time. I think it is premature to do so now, Senator.

Senator MITCHELL. Are the clinics in Richmond and Roosevelt directly related to the aging problem?

Dr. CUSTIS. No. If that is the question, yes, we can provide you with our experience from these prototypes.

[Subsequently, the Veterans' Administration submitted the following information:]

Experience with the prototype rural health clinics at Richmond and Roosevelt, Utah, has shown that a high quality of medical care can be provided through the outreach clinics. Since the clinics primarily provide post hospital followup services to veterans residing in isolated rural areas, outreach health clinic physicians and physician assistants work closely with the supporting Salt Lake City VAMC medical staff to assure continuity of care for patients discharged from the hospital. This allows closer monitoring of changes in the patient's medical condition and earlier referral to appropriate VA specialty clinics to avoid emergencies and the need for re-hospitalization. Veterans' care is then less fragmented between what they received at the VAMC and would have received from private health-care providers located in the multiple small communities where they live. While it is still too early to have hard data to demonstrate, it is the observation of clinic staffs that the patient is more compliant with his treatment plan when patient education can be reinforced through more frequent followup visits. It is expected that this kind of close followup evaluation of the clinics has been incorporated into the Medical Center's Quality Assurance/Utilization Review Program. A formal research project has also been submitted for funding to the VA Central Office's Health Services Research and Development Review Panel. If approved, the project will facilitate an extensive and indepth evaluation of the impact of the clinics upon the veteran and the medical center.

Senator MITCHELL. Let me get back a moment. You established clinics in Richmond and Roosevelt because they are rural outlying areas, not because there are just aging veterans there. Is that correct?

Dr. CUSTIS. Yes, I think that is an accurate statement. Our main purpose was a trial effort to see whether this variant of ambulatory care was workable for the VA.

Senator MITCHELL. And you say you are pleased with the results so far there?

Dr. CUSTIS. Yes, sir.

Senator MITCHELL. In your appearance last year, Dr. Brown, in opposition to my legislation, you presented several arguments both orally in your statement and in a letter to Senator Simpson from the Administrator. And there are a number of policy arguments based on, I believe the argument was, that it was not the way we do it. But the substantive arguments were, first, cost effectiveness. I now quote the Administrator's letter, in which he said, "In many instances it may be necessary as proper medical practice to rediagnose at the VA facility a veteran who was referred by the proposed clinic's treatment."

My question is: Has the problem of rediagnosis and corresponding, therefore, lack of cost effectiveness arisen in the Roosevelt and Richmond, UT clinics?

Dr. CUSTIS. It is an entirely different service, Senator. The problem of rediagnosis is not only recognized in the VA but even more so in the private sector. The average patient who leaves a small town or rural community and then goes to the Mayo Clinic is likely to have every diagnostic test that has previously been done repeated. That is just the way medicine is commonly practiced.

We do not favor that element of the proposal that was under discussion at the time of the hearings last summer for that very reason. Of all things we think are attractive, a strictly diagnostic outpatient effort is not one of them, in my opinion. Dr. Brown may wish to respond directly to the question you put to him.

Senator MITCHELL. My time is up. I just want to understand what you are saying. Are diagnosis performed at the clinics in Utah?

Dr. CUSTIS. Not to any extensive degree, certainly not any diagnostic procedure that requires laboratory apparatus.

Senator MITCHELL. I do not want to intrude on the chairman, who has been gracious in time. I apologize. I do have a number of other questions which I will submit in writing and ask that you respond to those. Thank you very much.

Thank you, Mr. Chairman.

Chairman SIMPSON. Thank you, George. It has been an issue that you have paid close attention to and it is one we have pursued too, George, on that level. I, too, represent a State that is very low in population, 100,000 square miles of area, so it is important to pursue it. It is also important to realize that many of these people are non-service-connected disabled and that has to be kept in scope, in my mind. I would think that we all would be pleased with health-care results, if we do not care about the amount of expense, and that is not a cruel or evil statement.

Senator MITCHELL. Mr. Chairman, that is very timely. I will not go on, but that was my next question. That was one of the arguments raised last year. You did comment on it, then in fact, in rather similar language. My followup question, which I will not pursue now because of time, is: As that relates to the clinics in Utah, has the misleading impression used as the argument against my bill occurred? But I will not pursue it now and I will submit that in my series of questions.

Chairman SIMPSON. The VA will be awaiting your questions and I can assure you after working with George Mitchell on Environment and Public Works, be prepared.

Senator MITCHELL. Which is where I have got to go now. Can I tell them I have got your vote, is that all right?

Chairman SIMPSON. I will hold it for a moment.

I have a myriad of questions that I do not have time to ask, so I will submit them in writing and they cover the whole spectrum, the post-traumatic-stress syndrome, health care for veterans who live in Puerto Rico, a myriad of things.

Just a couple of things I want to ask about, the expansion of this effort to provide bereavement counseling. I do not know, as I say, how the legislative branch got a visit upon these things, like immigration and nuclear regulation and veterans, but here is one that I should not even mumble about. I mean, who can be against bereavement counseling? But I am troubled by that. As we agonize about this budget, this is not directed at the sponsor in any way, but I am troubled by it as an expansion, which I do not think is appropriate. It is going to be now endowed upon veterans currently considered as peacetime veterans and nonveteran family members.

How are we going to explain that when we now institutionalize something which is done anyway by any thoughtful caring sensitive person? And that is at the time of death of the veteran, in discussions of pensions and benefits, a live human being is talking to another live human being and trying to be very responsive and I have seen that and I know how it works. It is very real. I hate to see it institutionalized like that, when it is going to take some benefits or some services from others.

If that is to become a VA benefit, bereavement counseling and readjustment counseling, to a nonveteran family member, that is what this is, if that is to become a VA benefit, do any of you believe or do you, doctor, know how far we might be from the next step of diluting VA benefits to provide other medical services to nonveterans? And is that not a real troubling thing as you perceive it?

Dr. CUSTIS. I understand your concern, Mr. Chairman. It is however, a very important element in hospice care, which is becoming so popular, not only in our society, but in Europe as well. Our favoring such an institutionalization of the program is based on our discomfort of stopping something that is already going on that involves civilian access to care.

Chairman SIMPSON. I think there is a very distinctive difference. Hospice care is the very real reason why we reduced the need for bereavement counseling, because those family members go through the anguish and the beauty of hospice care and that is what it is. I am a cosponsor of that and have been since I came here.

But anytime we are expanding ourselves to nonveteran family members and non-service-connected at these times, the service-connected veteran is going to pay the penalty somewhere down the line. Anyone that is not involved in seeing that is missing the point, because the party is over with regard to deficit and it does not matter what party you are in or who takes over next November.

So it seems to me we ought to be paying attention to that and not looking for expansion, especially in areas where we ought to be looking at eligibility along the whole spectrum.

Dr. CUSTIS. We have another example that I am sure you are aware of and that is the readjustment counseling. There counseling is also given to the veteran's family. That is part and parcel of adjusting the veteran's environment that is impinged upon by a family member. It is another example of service to family members.

Mr. HENDRICKS. Mr. Chairman, if I could comment, the bereavement counseling is merely a followup where counseling is already being provided to the family in connection with the treatment to the veteran. We do not think it is a major imposition on the system. We think it is a recognition of the humane care and treatment for the surviving family members. I do not have the cost figures, but we do not think the cost will be significant.

Chairman SIMPSON. Well, it never is when you want to do something. I do not know how—if a contractor does not want to do it, he tells you it will cost you a fortune; if he wants to do it, it is peanuts. And I have been there.

Anyway, I think we ought to be paying close attention to it, especially as you broaden it out. Our past, whatever was here, is for the service-connected disabled veteran, that was the original essence of the support system and we have broadened that and broadened that on down through the decades in an extraordinary way, far beyond what anybody ever dreamed.

[Subsequently, the Veterans' Administration submitted the following information:]

By way of further clarification, VA has long had explicit statutory authority to, and has long provided counseling and related services to families of veterans where such services are essential to the veteran's ongoing care. See 38 U.S.C. § 601(5) and (6). The enactment of the proposed bereavement counseling provision would not represent a precedent nor would it institutionalize the provision of benefits to nonveterans at the expense of the service-connected. Such a result would not occur, nor would it be permissible as a matter of law since priority for medical services must be afforded to the service-connected veteran.

Chairman SIMPSON. Now, I have just one other question. What happened to beneficiary travel that I asked you about 8 months ago? I asked for that report. That was due April 1, 1984. I asked about it 8 months ago, September, and 11 days after the due date set forth in Public Law 98-160, we have no report, not a twit of information or a whit, either one, advising us of the delays and, you know, I am not really tough, difficult, or nasty, but I want to know where that is. Because we wanted to find out the cost. They reduced us in that area. We know that. It requires that report. I also note that there are at least 14 questions that have not been answered with regard to followup questions on the February 8, 1984, budget hearing. You are responsive in most areas, but I do not know how else to get the message across, unless you do it some way such as this. Letters failed.

Construction priorities, Senator Cranston and I asked about that and have a letter no later than April 3, 1984, and I am going to tell you that I am going to consider promptness very important in that area. I realize that some of these areas are not within your province. But we had a mandated study for beneficial travel, its purpose was making management improvements and economies. What is the status of that study and when am I to get that, along with Senator Cranston?

Dr. CUSTIS. Mr. Chairman, we anticipated your question and Ms. Quandt is particularly prepared to respond.

Ms. QUANDT. Mr. Chairman, beneficiary travel is one of my pets too and we have a serious problem in responding to your request. The department has made every possible effort, including legislative changes and regulation changes to control that particular account. I believe we have testified to you before that we are aware there are places in the country which, in an effort to control travel, are not providing benefits authorized by law. We are not providing that benefit to veterans who should have it, simply because the funds will not carry us that far.

In view of our many studies and because of a small reorganization in the department, an office that probably should have carried out the study, because it would have been unbiased, did not do it, and it was then referred down to an area in my control. As you may recall, Congress and OMB have required that we do a user fee study of what would happen were we to charge user fees to our various beneficiaries. That contract was let to the MAXIMUS Corp. and in order to provide you with valid data, we felt it best of all to extend the contract and do a thorough travel management study. This is being done. We anticipate the report in mid-November of 1984.

In the meantime a letter-report in accordance with Public Law 98–160 is on its way to you.

Chairman SIMPSON. I will appreciate having that. As I say, I do not want to dump the whole load, but there are some other studies that I have asked for and I have not received, hospital and nursing home beds operated by the VA, that was due December 1. Nurse recruitment and retention, that was due February 26. Health Professional Scholarship Program, that was due March 1. The report on the pilot program on contract on alcohol and drug abuse treatment with community-based treatment facilities, that was due March 31. Beneficiary travel, April 1. And then, of course, the special pay of physicians and dentists. I do not know any other way to express this, but I guess the one that everybody understands, I am not going to go through markup after markup or construction resolution over construction resolution until I get that stuff. It is very simple. I guess I will leave it at that.

All right, thank you very much. I appreciate your being here and your testimony.

I would appreciate having written responses to these questions I will propose by April 19. That would be very helpful and not only that but required. Thank you. So thank you, Don, and we thank your group.

[Subsequently, the Veterans' Administration submitted the following information:]

The current status of reports due to Congress is as follows:

Report	Status
Report to Congress on Hospital and Nursing Home Beds Operated by the VA.	Pending OMB clearance.
Nurse Recruitment and Retention in the Veterans Administration	To OMB for concurrence April 12, 1984.
Annual Report on the Health Professional Scholarship Program	Transmitted to Congress March 28, 1984.
VA's Pilot Program for Contracted Care and Treatment and Rehabilitative Services with Community-Based Treatment Facilities for Eligible Veterans Suffering from Alcohol or Drug Dependence or Abuse Disabilities.	Transmitted to Congress May 3, 1984.
Beneficiary Travel Study	Transmitted to Congress April 9, 1984.
Operation of Special Pay Under Title 38, Section 4118 Authority	Transmitted to Congress April 27, 1984.

[The responses of the Veterans' Administration to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs; Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs; Hon. Strom Thurmond, a U.S. Senator from the State of South Carolina; and Hon. Rudy Boschwitz, a U.S. Senator from the State of Minnesota; follow:]

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. The community referrals and arrangements provision in S. 2514 suggests veterans with service-connection rated at 50 percent or more and veterans age 65 or older as target populations and provides such authority for veterans who have completed a VA alcohol treatment program. Do you agree with the targeting of these groups?

Answer 1. In relation to the Community Referrals and Arrangement Provision in S. 2514, VA medical centers already target the over 65 age group as a function of the VA's participation in the "Working Agreement for the Consortium on Information and Referral Services for Older People". Referrals to community-based programs by VA staff (as well as referrals by community agencies to the VA) are not based on age in an exclusionary sense; rather, referrals are based on need for services. It is the essence of the mission and purpose of the VA that the group of veterans who have service-connected disabilities rated at 50 percent or more be given a special priority for services.

Question 2A. In the general experience of the VA in promoting VA/community cooperation, what obstacles do you forsee in implementing the referral and arrangements for services provision in S. 2514?

Answer 2A. In the Information and Referral Program, the major VA experience in the area of referrals to community agencies, few administrative obstacles have been found in implementing the "Working Agreement for the Consortium on Information and Referral Services for Older People". Generally, Area Agencies on Aging (AAA) and other community agencies have welcomed and encouraged the VA's involvement in the community-based long term care components.

The obstacles that the VA has found in promoting VA/Community cooperation are that certain services are unavailable in communities or that the demand for such services exceeds the supply. Listed below are the unmet needs of the elderly, in ranked order, as determined by the Area Agencies on Aging (AAA).

Unmet Needs of the Elderly As Determined
by Area Agencies on Aging (Priority Order)

1. Transportation
2. Home Health Care
3. Nursing Home Care
4. Emergency Housing
5. Outpatient Medical Care
6. Adult Day Health Care
7. Information and Referral
8. Protective Services
9. Housing
10. Nutrition

Question 2B. What disadvantages result from a VA center of responsibility for this referral function? Is there a way to more directly involve the community?

Answer 2B. The VA has always maintained a referral function, formalizing its relationship with other federal and community agencies through the Information and Referral Program in 1975. This referral function is critical for all VA medical centers so that patients no longer in need of hospital or nursing home care are referred and placed at the most appropriate level of care in the community.

The VA and community-based agencies, especially in the long term care area, could become more involved in joint planning and service development. Legislation would be required to authorize the VA to use its expertise and in-kind resources to participate in the development of community based non-institutional health care programs. This would be similar to the more specific provision in the authority provided last year to mount joint program development in adult day health care with the communities around VAMCs. This will serve both veterans and non-veterans when such services are necessary in the treatment of veterans under chapter 17 of title 38.

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Question 3A. How do you effectively provide specific guidelines and transmit information to the individual medical centers on innovative new program models for alcohol treatment?

Answer 3A. Information on innovative new program models is transmitted primarily through regional training conferences some of which are sponsored by VA Central Office. Others are sponsored by locally initiated Regional Medical Education Center planning and budget. In addition, reports are distributed on VA multihospital studies of new treatment modalities, (such as the combined treatment unit which accepts all substance abuse cases, compared with the conventional treatment unit which admits alcoholic veterans or other substance abuse cases exclusively). Other sources of such information are reports of VA studies on treatment modalities which are available at VA medical libraries (i.e., April 1984 issue of Psychiatric Annals).

Question 3B. Please provide for the record copies of all VA circulars and directives that have been issued to the individual medical centers in alcoholism treatment in the past five years.

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Answer 3B.	Attached are the requested materials.
Question 4A.	Your "1980 Supplement to Alcoholism and Problem Drinking, 1970-1975 A Statistical Analysis of VA Hospital Patients" (March 1982) states that alcoholism-related disorders were the second largest category of diagnoses among VA inpatients next to heart disease. Is this still the case?
Answer 4A.	No. Alcoholism - related disorders are currently the third largest category of diagnoses among VA inpatients, following heart disease and neoplasms.
Question 4B.	What percentage of the veterans treated each year for alcohol and drug abuse have limited social, financial, and vocational supports and for these and other reasons, may be at greater risk for relapses and chronic alcoholism.
Answer 4B.	Significant employment and income problems have been reported in over 35% of admissions. Significant family problems have been reported in over 40% of admissions. Significant social (other than family) problems have been reported in over 20% of admissions.
Question 4C.	What special treatment programs do veterans receive that specifically address their high rate of relapse and how do these programs differ from other VA Alcohol Treatment programs?
Answer 4C.	(a) Treatment program activities which address the special needs of relapse - prone veterans include the utilization of treatment plan contracts which are developed at the outset of treatment, the use of vocational rehabilitation programs, AA activities, family therapy, medical treatment of alcohol-related

complications such as liver disease and malnutrition, and of outplacement into contracted community-based residential treatment and rehabilitation.

(b) These treatment plans differ from other alcoholism treatment plans in that they require more frequent use of post-detoxification outplacement into contracted community-based programs, or definitive medical treatment for the alcohol-related secondary diseases, and of job training and job placement services. The emphasis, in all cases, is on an individualized treatment plan.

Question 5. What are the average lengths of stay for veterans in your detoxification programs? Acute Inpatient Programs? Extended Rehabilitation Programs? Outpatient Programs?

Answer 5. These data are not presently available. A survey has been projected which will require extraction of such data from individual clinical records. The survey instrument is being developed in collaboration with the SVAC staff.

Question 6. What percentage of veterans treated in VA alcohol treatment programs each year return for additional treatment after 6 months? After 1 year?

Answer 6. Data related identifying the time lapse between hospitalizations in individualized cases and by diagnostic grouping are not available.

Question 7. **What specific outcome measures are used in your treatment units to determine the success or failure of a treatment episode?**

Answer 7. The outcome measures which indicate the success or failure of a treatment episode reflect pre-post assessments. The eight VA treatment goals are addressed by serial (pre-post) quantifications of problem size in each of the eight areas of concern.

An evaluation handbook for measuring constructive change toward each of the treatment goals has been developed for use by VA treatment programs and distributed to all programs. This "Handbook on Evaluation of Treatment of Drug and Alcohol Dependent Patients" (copy attached) provides a system for recording and measuring treatment experiences since the VA inpatient treatment episode, economic and personal management, interpersonal and social adjustment, physical and mental status, and dependence problems. Pages 22-28 of the Handbook provide follow-up measures to determine the extent and amount of change in each of the eight problem areas when these measures are compared with measures obtained earlier at admission (pages 14-19).

Question 8.	Please describe the difference between a psychosocial and psychiatric model for alcohol treatment. What type of approach is supported in the VA and why?
Answer 8.	There is considerable overlap between the psychosocial and the psychiatric models for alcoholism treatment. The psychiatric model, as one of the medical disciplines, emphasizes comprehensive assessment and holistic treatment. It provides an initial biomedical assessment and often utilizes medications in the treatment of withdrawal states, and may utilize antabuse to prevent alcohol relapse behavior. It looks for and treats the major psychiatric disorders which may on occasion complicate the alcohol abuse disorder. It refers patients to AA and other group support activities for prevention of alcohol abuse behavior. The psychiatric model utilizes vocational and psychosocial assessments in developing a profile of the patients medical, psychosocial and vocational strengths and special needs. It sponsors a broad, multimodal system of treatment activity options, and develops a highly individualized treatment plan. It provides a medical oversight function for treatment.

The psychosocial model for alcohol treatment emphasizes the social causes of alcoholism, particularly family and job conflicts, the absence of healthy peer groups, the absence of normalizing growth experiences, the absence of self-help skills and other coping skills. It emphasizes the importance of VA program linkages with non-VA programs particularly those which provide social skills, and job placement services. It focuses on the strengths of families and healthy peer groups. Counselors work in a number of settings, such as with family and couples.

The VA programs support both of these models and utilizes a combination of them in most treatment plans.

Question 9. The evaluation of the 5 year pilot program to contract for halfway house care for alcoholism treatment was due to be submitted to Congress on March 31, 1984. When will the report be completed?

Answer 9. The report is currently in the late stages of Central Office review and will be provided to the Congressional committees in the very near future.

Question 10. In a March 13, 1984 letter, Mr. Walters stated that alcoholism was second in the list of 15 research and development priorities. Please provide for the record a list of all research projects currently underway pertaining to alcoholism treatment, specific goals of the individual projects, and projected completion dates.

Answer 10. Enclosed are computer generated Project Summaries retrieved from our Research and Development Information System (RDIS) using codes related to Alcoholism and detoxification Information identified for each project includes:

Project Title and Number
Investigator Name
VA Medical Center Location
Type (Initial or Progress) and Date of Last Report
Project Summary
Completion Date

Only Centrally Merit-Reviewed Approved Medical Research projects have been included.

In addition to the enclosed projects, there are approximately 100 locally reviewed and approved projects.*

*[These documents are available in the Committee's files.]

Question 11. Preliminary summaries of MEDIPP 1983 hospital bed projections indicate that there are 23,764 operating beds for psychiatric care. Bed levels for FY 1990 for psychiatric care are projected to be 25,297, an increase of 1,533.

Please provide the Committee with a breakdown for both FY 1983 and FY 1990 of the distribution of the psychiatric care beds, including those used for alcohol treatment and rehabilitation, drug treatment and rehabilitation, and inpatient Post-traumatic Stress Disorder Treatment.

Answer 11. For FY 1983, there were 23,766 average operating psychiatry beds in VA medical care facilities. Of these 23,766 psychiatry beds, 3,205 psychiatry beds were identified for the treatment of alcohol dependent patients, 955 psychiatry beds were identified for the treatment of drug dependent patients and 273 psychiatry beds were identified for the treatment of patients suffering from Post-traumatic Stress Disorder.

The 1983 MEDIPP submissions projected a need for 25,391 psychiatry beds by 1990. Of these 25,391 projected psychiatry beds, 3,425 beds have been projected for the treatment of alcohol dependent patients and 955 beds have been projected for the treatment of drug dependent patients. The MEDIPP submissions for 1983 did not fully address the need for inpatient Post-traumatic Stress Disorder units. Following review of the 1983 MEDIPP submissions, Mental Health and Behavioral Sciences Service recommended each medical district assess its needs for an inpatient Post-traumatic Stress

Disorder unit. If the medical districts determine a need for these programs, they will identify their needs in the 1984 MEDIPP submissions.

Question 12. You have said that because PTSD is new to the list of mental health disorders, classified by the American Psychiatric Association for the first time in 1980, there is disagreement among mental health professionals regarding its proper diagnosis and treatment, and that it would be premature for the VA to establish any specific policies, directives or guidelines for the VA medical centers to aid them as they provide treatment for veterans with this disorder.

Answer 12. I have indicated previously that there is "less than unanimity" among mental health professionals concerning the treatment of Post-traumatic Stress Disorder. This lack of agreement reflects the fact that active and healthy debate is going on in the mental health profession and among VA mental health professionals concerning the preferred approach for the treatment of Post-traumatic Stress Disorder. Some skilled mental health professionals believe that inpatient treatment is required for Post-traumatic Stress Disorder. Other equally skilled professionals believe that outpatient treatment is preferable. Parallel controversies exist throughout medicine concerning the best treatment for a wide variety of medical, surgical, and psychiatric conditions. From such controversy, comes progress through active exchange of ideas, research, and careful daily reexamination of clinical experience.

Question 12A. Wouldn't this lack of consensus in fact emphasize the immediate need for some general guidance and coordination from Central Office?

Answer 12A. The presence of healthy professional debate demonstrates the importance of the issue, and indicates the existence of active evolution in the field. Provision of centralized guidance can only interfere with this constructive development of new perspectives and information.

Question 12B. VA Central Office issues a large number of circulars and guidelines to the field on the provision of certain medical care services. How do you decide when such guidelines should be issued and when they shouldn't?

Answer 12B. Central Office issues circulars and/or guidelines to the field based on the following considerations and/or reasons:

1. When a significant body of medical and/or scientific facts become available and it would be of vital importance to notify health care professionals in the system.
2. When emergent or urgent issues arise which have specific risk potential, e.g., circulars dealing with Legionnaire's disease or AIDS.
3. Circulars dealing with significant safety and/or hazardous issues, e.g., defective equipment, (ventilator alarms, central venous catheter hazards, etc.)
4. When it is important to promulgate the opinions and/or recommendations of specific advisory committees, e.g., Advisory Committee on Female Veterans, Advisory Committee on Former Prisoners of War.
5. Circulars are issued which pertain to various preventive health care issues, e.g., flu vaccine, Hepatitis B. vaccine.
6. Issues concerning the protection of patients; for example, circulars dealing with violent behavior of spinal cord injury patients, control of window openings, areas in medical centers unsafe for patients.
7. Guidelines related to cost savings; for example, low temperature laundry, pre-admission surgical screening.

8. Circulars and guidelines are issued to comply with law; for example, circulars dealing with Public Law 98-160 as it pertains to preventive health care issues and the mandates contained in the Public Law; another example would be the addition of a disorder to a list of already promulgated disorders for the purpose of service connection (dysthymic disorder as an addendum to P.L. 97-37).
9. Guidelines are published as they relate to the required performance of duties by specific health care professionals, e.g., certified nurse specialists and registered nurse practitioners.
10. Circulars may be issued to provide for the uniformity in data collection; for example, the circular pertaining to the Statistical Tracking System for the former POW.
11. Circulars are issued dealing with legal and/or humanitarian issues: patient privacy, patient rights, do-not-resuscitate or right-to-die.
12. Circulars are issued with information regarding administrative changes in Central Office.
13. Circulars are issued pertaining to quality of care issues. For example, advice to the field in areas of compliance with various surveying authorities (JCAH, SERP, IG, GAO).

It will be noted that circulars are not issued pertaining to the day-to-day clinical care that is being provided for patients. Circulars are not promulgated simply to alert the field to existence of new clinical entities unless there is a specific hazard or infectious component such as the example cited above for Legionnaire's disease or AIDS. With respect to PTSD or any other mental health disorder, we are not aware of any circular having been written pertaining to psychotherapy as a treatment modality.

Question 12C. How can you justify the allocation of resources for PTSD units in certain parts of the country, but not play a role in ensuring that resources for such services are distributed in other areas where there might be a need?

Answer 12C. Each VA medical center is encouraged to utilize its budget in a manner which it feels would most efficiently and effectively provide care for its patients. Thus, PTSD units have been established through local initiatives and have not been funded by specific central office direction and special funding.

In addition, the needs of Vietnam veterans with PTSD are being addressed along with all other needs through the Department of Medicine and Surgery's Medical District Initiated Planning Process (MEDIPP). Each medical district will be continually reassessing any need for PTSD beds and plan development of such units within the district boundaries, if indicated.

Question 13. What do you see as the role — now and in the future — of the VA regarding treatment, research, and training concerning PTSD?

Answer 13. Post-traumatic Stress Disorder is a condition which occurs when individuals are exposed to profound levels of psychological stress usually of a life threatening nature. There are many examples of Post-traumatic Stress Disorder among civilian populations such as, rape victims, natural disaster victims, kidnap victims, and others. Vietnam veterans and other combat veterans are a relatively specialized sub-group of individuals with Post-traumatic Stress Disorder.

The Veterans Administration currently is a leader among mental health professionals in the provision of treatment, education, and research concerning Post-traumatic Stress Disorder. The VA will continue this leadership role through the efforts of its highly skilled cadre of mental health professionals.

Question 14A. What is the relationship between the Readjustment Counseling Center charged with the management of the Vet Center program and the Mental Health and Behavioral Sciences Service under whose authority the inpatient treatment of PTSD lies?

Answer 14A. The Readjustment Counseling Service provides part of the spectrum of the services needed by Vietnam Era veterans including readjustment counseling, family counseling, job counseling, and referral services. The Mental Health and Behavioral Sciences Service provides services for those veterans needing treatment for psychiatric conditions including alcoholism, depression, and Post-traumatic Stress Disorder. Vet Centers, and VA medical centers and clinics provide care for veterans with Post-traumatic Stress Disorder. Inpatient treatment for Post-traumatic Stress Disorder is needed for those veterans with severe Post-traumatic Stress Disorder. These veterans frequently have associated other conditions including depression, suicidal ideas, and alcoholism.

Readjustment Counseling Service was originally a part of the Mental Health and Behavioral Sciences Service. Since the creation of a separate service for Readjustment Counseling, active collaboration between the services has continued.

Question 14B. What specific steps are taken to ensure that knowledge about the diagnosis and treatment of PTSD is disseminated to both the Readjustment Counseling and Mental Health Services?

Answer 14B. The Readjustment Counseling Service has an active an ongoing training program for its Vet Center staff members. Coordinated by the Regional Medical Education Centers, these training programs ensure that Vet Center team members are actively informed about Post-traumatic Stress Disorder. Mental Health and Behavioral Sciences Service and Readjustment Counseling Service actively collaborate with Regional Medical Education Centers in the development and implementation of training programs for VA medical center staff members. In addition, VA professionals from both Readjustment Counseling Service and Mental Health and Behavioral Sciences Service have been active in providing training, education, and contributions to the professional literature concerning Post-traumatic Stress Disorder diagnosis and treatment.

Question 15. What broad guidance can be issued to the field which would enable the individual medical centers to continue to develop their own treatment programs for PTSD and yet ensure that care is coordinated and knowledge is disseminated among districts or regions nationwide?

Answer 15. A variety of program guidance can be issued to the field in general terms which may facilitate the dissemination of knowledge. These include program guides, information letters, etc.

Question 16A. How many specialized education efforts on PTSD have already been offered by the Regional Medical Education Centers and what is the total number of VA health care personnel who have attended these training programs?

Answer 16A. The Regional Medical Education Centers have offered a total of 40 educational programs on PTSD to VA health care personnel since 1979. These 40 programs have had a total of 2,251 attendees drawn from approximately 1,000 VA health care staff who deal with PTSD patients.

Question 16B. What exactly did the programs include, how many days did each program last and what specific topics were covered?

Answer 16B. PTSD education efforts were presented to both Veterans Outreach Center staff and to VA hospital staff. Both groups received training and orientation on the Vietnam experience and combat stress, and on the assessment and management of PTSD patients. Outreach staff training emphasized individual, group, and family counseling techniques and criteria for referral to hospital centered PTSD care programs. Training for hospital staff placed greater emphasis on the psychodynamics of PTSD for the treatment of the more severely impaired PTSD veterans.

Length of the PTSD training is defined in terms of classroom instructional hours, as a number of programs were not totally dedicated to PTSD. A summary of each PTSD offering conducted to date is attached.

SUMMARY OF RMEC PTSD TRAINING TO DATE

PROGRAM TITLE	LENGTH OF PTSD COURSE IN HOURS	# TRAINEES
1. Outreach, Phase I	12	32
Specific Topics: Review of psychological stress in combat with specific emphasis on Vietnam conflict. Review Case History, discussion on 10 year follow-up of veterans with PTSD. Specific treatment and interventions to facilitate the healing process; counseling techniques for PTSD anger and violence.		
2. Outreach, Phase I	12	35
Specific Topics: Repeat of program #1.		
3. Outreach, Phase I	12	30
Specific Topics: Repeat of program #1.		
4. Stress Disorders	18	22
Specific Topics: Definition and course of PTSD (delayed stress) related stressors; symptoms; treatment process; stress reduction.		
5. Stress Disorders	18	40
Specific Topics: Repeat of program #4.		
6. Outreach, Phase II	15	42
Specific Topics: Overview of combat related stress reactions; PTSD; PTSD and conjugal therapy; PTSD treatment issues; Vietnam veteran and management of violence; coping with Vietnam veteran's PTSD.		
7. Outreach, Phase II	15	35
Specific Topics: Repeat of program #6.		

PROGRAM TITLE	LENGTH OF PTSD COURSE IN HOURS	# TRAINEES
8. Outreach, Phase I	20	32
Specific Topics:	Vietnam veteran's with PTSD: family and group counseling; PTSD treatment; PTSD in disabled/women and minority veterans; PTSD legal issues; pre-release PTSD counseling; PTSD and significant others; sexual disfunction and substance abuse.	
9. Outreach, Phase I	20	29
Specific Topics:	Repeat of program #8.	
10. Outreach, Phase III	42	130
Specific Topics:	Diagnosis and treatment of PTSD including: group counseling, crisis intervention; dealing with anger; moral/ethical issues; PTSD claims; substance abuse; domestic violence; clinical assessment; and disabled veterans.	
11. Outreach, Phase IV	15	150
Specific Topics:	Nature and prediction of PTSD: Legal issues; group counseling, disabled veterans, crisis intervention; multi-nodal therapy; marital and family treatment; case management and assessment; female PTSD veterans; issues with women partners; current research in PTSD; substance abuse; case conferencing for the PTSD veteran.	
12. PTSD	11.5	40
Specific Topics:	Assessment of PTSD: Definition of PTSD; personality issue; combat stress and symptom formation; diagnosis. Treatment of PTSD: Treatment principles; group therapy, Veterans Outreach Center counseling; staff responses to Vietnam veteran.	
13. PTSD	11.5	48
Specific Topics:	Repeat of program #12.	

PROGRAM TITLE	LENGTH OF PTSD COURSE IN HOURS	# TRAINEES
14. Veteran Center Team Leader Training	14	31
Specific Topics: Clinical case management; clinical research; Vietnam veteran legal issues; confidentiality; and incarcerated PTSD veterans.		
15. PTSD	14	71
Specific Topics: Assessing for PTSD: Fighting the war and returning home; civilians and the Vietnam war; definition of PTSD; combat stress and symptom formation; PTSD versus character pathology; women who served in Vietnam; multi-method assessment. Treating PTSD: General principles; women staff and male Vietnam veterans; group psychotherapy; imaginal flooding and catharsis; Veteran Outreach Center functions and VAMC interactions; staff responses to Vietnam veterans.		
16. PTSD	12	85
Specific Topics: Repeat of program #15.		
17. Outreach, Phase V	20	175
Specific Topics: PTSD Topics: Group therapy; couples/family counseling; correct PTSD treatment modalities; Gestalt therapy; PTSD research findings and follow-ups; initial assessment; differential diagnosis of PTSD; treatment of black PTSD veterans; case conferencing; case management and referral; clinical supervision; crisis intervention; disabled PTSD veterans; female PTSD veterans; treatment of Hispanic PTSD veterans; inpatient treatment of PTSD; legal, moral and ethical issues; substance abuse; women partners.		
18. Outreach, Phase IV	16	51
Specific Topics: PTSD and marriage/family; clinical assessments; individual counseling; interviewing PTSD veterans; psychopharmacology; family violence; crisis intervention.		

PROGRAM TITLE	LENGTH OF PTSD COURSE IN HOURS	# TRAINEES
19. Treatment of PTSD	13	81
Specific Topics: Overview of PTSD; use of individual therapy; use of group therapy; family therapy; crisis intervention; rap and support groups.		
20. Treatment of PTSD	13	72
Specific Topics: Repeat of program #19.		
21. Operation Outreach Conference 1984	10	77
Specific Topics: Readjustment counseling for the PTSD veteran; individual, group and family therapy; crisis intervention; stress management.		
22. Family Therapy: Its Applications	2	75
Specific Topics: Special consideration in family therapy for the PTSD patient.		
23. Family Therapy: Its Applications	2	47
Specific Topics: Repeat of program #22.		
24. Family Centered Intervention for PTSD Veterans	12	126
Specific Topics: Understand basic components of PTSD; understand ways in which PTSD can interact with family problems; initial intake interview with PTSD family; screening/selecting families likely to benefit; family treatment planning and evaluation.		
25. PTSD	16	56
Specific Topics: 1. Historical aspects of Vietnam War and Era. 2. Importance of pre Vietnam character. 3. Effect of Vietnam experience on psycopathology. 4. Recognition and treatment of acute, chronic and delayed PTSD.		

	PROGRAM TITLE	LENGTH OF PTSD COURSE IN HOURS	# TRAINEES
26.	Integrated Approach to Readjustment Counseling Service	21	60
	Specific Topics: PTSD in the outreach program; outreach and readjustment techniques for PTSD; designing services for women Vietnam veterans; PTSD in minority veterans and family; PTSD program administration.		
27.	PTSD: PHE Model	24	111
	Specific Topics: Multidisciplinary treatment of PTSD; planning hospital based plans for PTSD; identify and clarify PTSD treatment team roles and functions; establish treatment plans.		
28.	PTSD	12	30
	Specific Topics: Overview of PTSD: combat stressors; diagnosis, assessment, adjudication; role of Veteran Outreach Center and VAMC; psychotherapy for combat veterans; treatment modalities, management disorders; female veterans with PTSD.		
29.	PTSD Mini-Residency	24	5
	Specific Topics: Psychiatric update on PTSD; clinical practicum on diagnosis and treatment of PTSD veteran and family; and related issues of drug abuse, sleep disorders, anger and hostility; treatment modality and choice of therapies.		
30.	PTSD Mini-Residency	30	1
	Specific Topics: Repeat of program #29.		
31.	MD #28 PTSD Update	16.5	44
	Specific Topics: Advances in diagnosis and treatment. Issues in psychopharmacology; crisis intervention, substance abuse.		

	PROGRAM TITLE	LENGTH OF PTSD COURSE IN HOURS	# TRAINEES
32.	Reaching the Person in Crisis Specific Topics: The assaultive patients: treatment procedures and dealing with anger and hostility and the Vietnam veteran.	2.5	42
33.	Reaching the Person in Crisis Specific Topics: Repeat of program #32.	2.5	58
34.	Dealing with Stress Disorders Among Vietnam Veterans Specific Topics: Combat stress; uniqueness of Vietnam war; self awareness and attitudes of staff toward Vietnam veterans; intervention and treatment approaches.	13	49
35.	Dealing With Stress Disorders Among Vietnam Veterans Specific Topics: Review of PTSD; discussion and workshop on clinical experiences in the management and treatment of PTSD.	12	47
36.	Training for Operation Outreach Specific Topics: Stressors and reaction to Vietnam combat.	2.5	26
37.	Training for Operation Outreach Specific Topics: Historical overview of combat stress; anger and violence of Vietnam veteran; stressors and reactions to combat.	3	27
38.	PTSD and the Vietnam Veteran Specific Topics: Overview of Vietnam experience; referral precedures; adjudication; clinical perspective of Vietnam experience; impatient treatment programs; Veteran Outreach Center programs.	8	65

PROGRAM TITLE	LENGTH OF PTSD COURSE IN HOURS	# TRAINEES
39. PTSD Conference	7	54
Specific Topics: Staff sensitization to the Vietnam veteran and their problems; assessment and diagnosis of PTSD; differential diagnosis; treatment approaches; new trends in PTSD patient management.		
40. PTSD	7.5	20
Specific Topics: Diagnostic procedures; research on the combat Vietnam veteran; substance abuse; clinical treatment; referrals and services.		

Question 17A. What steps have been taken thus far to pursue the development of a center for Post-traumatic Stress Disorder?

Answer 17A. It has been agreed to develop a center for Post-traumatic Stress Disorder at the Cleveland/Brecksville VAMC.

Question 17B. Which Central Office officials have participated in discussions concerning the development of such a VA center and what specific roles have they played in the discussions?

Answer 17B. Dr. Custis, Dr. Gronvall, Dr. Brown, Dr. Blank, and Dr. Lipkin have participated in discussions.

Question 17C. When do you expect to complete such discussions?

Answer 17C. Within 60 days.

Question 17D. How soon after that do you expect such a center to be established?

Answer 17D. During the last quarter of FY 1984.

Question 17E. If such a center was established, what specific steps would take to ensure that the results or research conducted by the center were disseminated to all VA medical centers and not just those few with inpatient PTSD units?

Answer 17E. As research projects are completed, it is usual practice to encourage the submission of such research results to professional journals. This ensures dissemination of useful research results to the entire mental health field.

Question 18A. Where does PTSD treatment and research currently fall as far as other VA priorities are concerned?

Answer 18A. Post-traumatic Stress Disorder and the needs of Vietnam veterans have received high priority from the Veterans Administration. The development of new treatment programs within existing resources is receiving careful consideration and will be carefully reviewed in this years MEDIPP submissions. (See answer to 18.B.)

Question 18B.

If research in PTSD were made a priority research issue for the VA, do you feel that there are a sufficient number of investigators who would desire and be qualified to conduct projects?

Answer 18B.

Research in PTSD has been a high priority program for the VA's Office of Research and Development since July 1979. At that time a special solicitation for research proposals in PTSD was issued. As of April 1984 there were six investigators who have been allocated $368,621 for their PTSD research in FY 1984. It is expected that the number of scientists interested in conducting PTSD research will increase in the comming years. To stimulate research in this area guidelines for research on PTSD was issued in March 1984 and a workshop is planned for October 1984 to help interested scientists develop their research programs in PTSD.

Question 18C.

With regard to research in the diagnosis and treatment of post-traumatic stress disorder, what collaborative arrangements have you considered with other agencies such as the National Institute of Mental Health?

Answer 18C.

Collaboration with the National Institute of Mental Health (NIMH) began in 1978 with President Carter's message to Congress, "More research needs to be done with the problems of Vietnam-era veterans. I am directing both the Veterans Administration and the National Institute of Mental Health to initiate studies in this area".

A meeting to encourage this collaboration was held with the Deputy Administrator of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) and the Veteran Administration's Assistant Chief Medical Director (ACMD) for Research and Development in July 1979. Subsequently, numerous discussions, workshops and small working group meetings have occurred between various NIMH and VA personnel. Recently, at a VA ad hoc committee meeting to develop PTSD research guidelines two of the eleven person committee were NIMH science-administrators. Within the past week, an invitation was extended to the NIMH personnel to participate with the VA in a workshop scheduled for October1984. This workshop is designed to assist investigators to develop research proposals in PTSD.

Question 19A. How long has the Mental Health and Behavioral Sciences Service been without a permanent Director?

Answer 19 A. Since December 1, 1983

Question 19B. What specific efforts have you made to fill this position and by what date do you expect the position to be filled?

Answer 19B.

1. A Search Committee has been established.
2. Advertisement and solicitation for the position have been made.
3. All applications within the proscribed time frame have been received.

4. First screening of applicants will take place the week of April 23, 1984.
5. Final committee recommendation will be made to the ACMD for Professional Services by June 1, 1984.
6. Probable date of nomination and selection will take place between June/84 and September/84

Question 20A. Please provide to the Committee for the record a complete list of staff, by area (Psychiatry, Psychology, Alcohol and Drug Abuse, etc.) title and function, assigned to the Mental Health and Behavioral Sciences Service.

Answer 20A. The attached organizational chart answers this question.

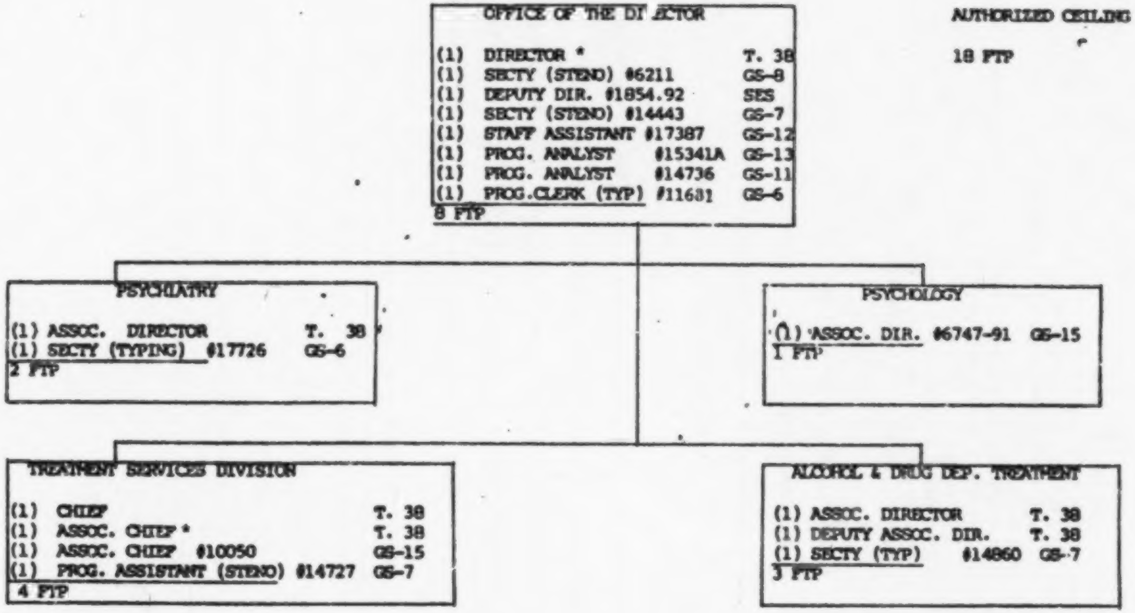
Question 20B. Do you feel this is an adequate number to effectively manage the VA's mental health programs?

Answer 20B. With the two positions, which are marked on the organizational chart, currently unfilled we are understaffed to manage the VA's mental health programs.

MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICE
DEPARTMENT OF MEDICINE AND SURGERY
OFFICE OF PROFESSIONAL SERVICES

AUTHORIZED CEILING

18 FTP



OFFICE OF THE DIRECTOR

(1) DIRECTOR * T. 38
(1) SECTY (STENO) #6211 GS-8
(1) DEPUTY DIR. #1854.92 SES
(1) SECTY (STENO) #14443 GS-7
(1) STAFF ASSISTANT #17387 GS-12
(1) PROG. ANALYST #15341A GS-13
(1) PROG. ANALYST #14736 GS-11
(1) PROG.CLERK (TYP) #11681 GS-6
8 FTP

PSYCHIATRY

(1) ASSOC. DIRECTOR T. 38
(1) SECTY (TYPING) #17726 GS-6
2 FTP

PSYCHOLOGY

(1) ASSOC. DIR. #6747-91 GS-15
1 FTP

TREATMENT SERVICES DIVISION

(1) CHIEF T. 38
(1) ASSOC. CHIEF * T. 38
(1) ASSOC. CHIEF #10050 GS-15
(1) PROG. ASSISTANT (STENO) #14727 GS-7
4 FTP

ALCOHOL & DRUG DEP. TREATMENT

(1) ASSOC. DIRECTOR T. 38
(1) DEPUTY ASSOC. DIR. T. 38
(1) SECTY (TYP) #14860 GS-7
3 FTP

RECOMMENDED:

JACK R. EWALT, M.D.
Director, Mental Health and
Behavioral Sciences Services

APPROVED:

3/30/83

CARL W. HUGHES, M.D.
ACMD for Professional Services

Question 21. You have said that it is not necessary to establish a special management position in Central Office to establish policy, provide guidance, coordinate care, conduct research, and ensure training for the treatment of PTSD because it would set a precedent for the establishment of such positions for other specific mental health disorders.

Central Office currently has an Associate Director for Alcohol and Drug Abuse under the Mental Health and Behavioral Sciences Service. Why do you believe it is necessary to have such a position for the treatment of alcohol and drug abuse disorders which are non-service-connected disabilities, but that it is not necessary to have a separate Associate Director for the treatment of PTSD which is a service-connected disability?

Answer 21. In 1972, Alcohol and Drug Abuse was a separate service. When the Alcohol and Drug Abuse Service was combined with Mental Health and Behavioral Sciences Service a position of Associate Director for Alcohol and Drug Abuse was established. It has been necessary to have a separate Associate Director for Alcohol and Drug Abuse because of the large number of program management initiatives required for the alcohol and drug dependence programs, including numerous special reports on treatment activities required by the Congress. In addition, the numbers of patients having alcoholism or alcohol related problems is several times larger than the number of veterans with Post-traumatic Stress Disorder.

We believe that, because of the complex and unique nature of PTSD, treatment for this disorder should be coordinated through our Psychiatry Service. Also, delivery of PTSD care and education is being furnished effectively through close cooperation among several services in DM&S. VA's official opposition to the establishment of a separate service for PTSD has not been based on a concern over its establishing a precedent. An objection along those lines was not raised in either a report to ongress or hearing testimony.

Question 22. At an oversight hearing before the House Veterans Affairs Committee on June 15, 1981, VA testimony supported a change in the automobile adaptive equipment program which would limit adaptations to one car in three years.

A draft circular revising certain aspects of the automobile adaptive equipment program and including the "one in three" change was prepared by Prosthetic & Sensory Aids Service, in early 1983. However, the final circular released in May 1983 provides for a continuation of the current policy to allow adaptations for three vehicles in two years.

Question 22A. What were the specific reasons that one automobile in three years was originally proposed and supported by the VA ?

Answer 22A. A program evaluation conducted by the Office of Program Planning and Evaluation Service cited some instances where veterans were provided replacement adaptive equipment more frequently than might have been essential. To resolve the suspected abuse, the report recommended prohibiting the intrafamily transfer of vehicles and limiting reimbursement to one vehicle in three years. These recommendations were included in a "draft" circular on the automoile adaptive equipment program, however, the one in three limitation was dropped because widespread abuse could not be substantiated and it was felt that this limitation was too restrictive.

Question 22B. Do the reasons still apply to the use of the program today ?

Answer 22B. Many of the previously identified excesses in the adaptive equipment program have been corrected with the issuance of DM&S Circular 10-83-1 which provided improved administrative guidelines.

However, we recognize that early vehicle replacement is a potential area of abuse that still exists. We believe that the potential for abuse should be reduced but, we are concerned that the proposed one in three limitation would be too restrictive to allow needed program flexibility. Severley disabled veterans require extremely dependable transportation to permit independence and to reduce the possibility of potentially hazadous situations which may be detrimental to the health and safety of the veteran. Also, we recognize the difficulty in defining "exigent circumstances" that would cover all situations. We believe that the "one in three" limitation would more likely affect a veteran who, on rare occasion, desired to change a vehicle more frequently. As an alternative, we recommended adopting a one vehicle in two year limitation.

Question 22C. How would the change I have proposed, to allow a transfer of title of an adapted vehicle, affect a veteran's needs to have the options of adapting a new vehicle every nine months ?

Answer 22C. Eliminating the prohibition of "one vehicle at any one time" would permit the veteran, if he/she elected, to retain the use of an adapted vehicle. This vehicle could serve as a spare should the veteran's primary vehicle become temporarily disabled and possibly reduce usage of the nine month option. However, the time limitation suggested in S2210 would eliminate the nine month option, therefore, this appears to be a mute question.

Question 23. *A 1980 General Counsel opinion states that the VA does not have authority to furnish telecaption TV adaptors as a necessary part of outpatient care for eligible veterans because it cannot be established that there exists a medical need for furnishing such devices to totally deaf veterans.*

Question 23A. *The VA provides TTY (teletype) systems and hearing dogs for veterans who are hearing impaired but does not require these veterans to demonstrate that they have a "morbid mental condition" in order to receive them. How do these devices differ from telecaption TV decoders in their ability to provide a medical or rehabilitative benefit rather than a psychosocial one ?*

Answer 23A. *Both TTY systems and hearing dogs are provided based on a veteran's particular needs, neither item is routinely provided to all "totally deaf" or "profoundly deaf" veterans. TTY systems are only furnished when emergency personal communications are necessary to insure the safety and health of the veteran or, when this is a rehabilitative benefit, usually associated with employment, to be achieved. Hearing dogs are rarely requested or provided. They are furnished at VA expense only when necessary for the rehabilitation of the veteran. Usually the circumstances are unique and the dog is required for special purposes, e.g., taking care of infants while the wife works. To our knowledge, only one or two dogs have been provided by the VA.*

Question 23B. *If the purpose of the prosthetic and sensory aids is to provide a direct form of assistance to overcome a specific handicap. How is a TV decoder, which would provide a communication device for a deaf veteran with a communication handicap, different than an automatic page turner for a paralyzed veteran with a mobility handicap ?*

Answer 23B. *Page turners are only provided to high level quadraplegic veterans who are so severely disabled that they cannot* *hold a book or turn its pages. Frequently, these veterans are involved in vocational rehabilitation programs and the ability to read written material is essential to allow completion of their vocational objective. On the other hand, telecapting devices are closely associated with entertainment and it is difficult to establish the relationship to medical treatment. However, we are not unsympathetic to the overall needs of the deaf veteran; and, we will review the criteria under which medical need is determined for issuing these devices.*

Question 24. It has been said that "better managment of pain and symptoms is a medical skill that can be conveyed by better education. The hospice movement may have made its contribution by sensitizing practitioners to this deficit. Such care does not require formal designation as a hospice."

Do you agree with this statement? If so, why; and if not, why not?

Answer 24. The control of pain and other symptoms is a medical skill which can be disseminated by better education and by the sensitizing of practitioners. While malignant neoplasms are associated with acute pain, there are other diseases in which intractable pain is a part of the disease process for which pain management is essential for the comfort of of the patient. Pain control and management can and should be practiced throughout the hospital. As the literature consistently states, hospice care is a concept of care and is not limited to a formal designation. The sensitizing of medical staff to the methods of pain control developed by the hospice movement will contribute to the comfort, well-being and mental health of patients which constitutes good patient care.

Question 25A. There is disagreement among health planners and policy makers concerning the cost-effectiveness of hospice care. What are your views on its cost-effectiveness?

Answer 25A. Cost effectiveness studies of hospice care are limited and require more research for an informed judgment to be made. The literature on the outcomes and costs of hospice care is primarily anecdotal. The two studies which considered program costs are the HCFA sponsored study conducted by Brown University and the VA sponsored study at VAMC West Los Angeles. Although both projects have published portions of their study, the entire section on costs and cost effectiveness are not yet available.

Question 25B. Which models are the most cost-effective (inpatient, free-standing or home based) or must we wait until more research is conducted before rendering a verdict on this question?

Answer 25B. Studies on the cost effectiveness of the various models of hospice care require more investigation. There is no doubt that a hospice model with a full range of services (inpatient, home care and consultation units) is expensive. While the cost data from the West Los Angeles project indicates that hospice care is as costly as traditional care, the generalizability of the study needs further examination before an informed judgment can be made. In general, it does appear that for the same "cost", an improved quality of life for the terminally ill is achieved.

Question 26. In your experience, what is the most important component in providing care to the terminally ill?

Answer 26. The style of care for the terminally ill patient is the major component of care that was developed through the hospice movement. With a heavier staffing ratio more time is spent with the patient and family in giving emotional support and personal attention while managing pain and other symptoms for the comfort of the patient. This contributes to the lowering of anxiety and depression of the patient and leads to the high level of satisfaction with care rendered. Maintenance and restitution of the patient and family is achieved in a significantly enhanced manner.

Question 27. I have heard that the grieving process for the death of a loved one can take from 6 to 18 months. Is that correct, and what is the relation to that period of six months of bereavement counseling services?

Answer 27. The needs of the surviving family members do not end with the death of the patient. A period of grieving and reactions to loss that accompany a terminal illness requires the support and therapeutic intervention of the professional staff. Bereavement counseling is one of the unique features of the hospice concept of care. Program standards of the National Hospice Organization stipulates that bereavement services be provided for a period of at least one year. The Joint Commission on the Accreditation of Hospitals requires that bereavement services be available "for an appropriate period of time". The Medicare program requires bereavement counseling for a period of up to six months, although it is not a reimbursed service. The wide range in the period of time for bereavement counseling is reflective of the need for flexibility in the provision of this restitution portion of the service.

Question 28. Since there seems to be a shortage of mental health care providers and understaffed Vet Centers, how would we ensure that veterans would receive first priotity—in a case where resources to provide counseling are limited—if eligibility for Readjustment Counseling were extended to military personnel still on active duty?

Answer 28. The treatment program in Vet Centers depends to a great extent on peer counseling, through the use of group therapy. Should section 4 of S. 2269 be enacted, active duty personnel to whom services are provided would be integrated into already existing groups with veterans. Numbers of active duty personnel seeking treatment should be sufficiently small enough that the impact would not be great. Vet Centers are servicing a population of veterans in need estimated to be 700,000 - 800,000 in size as of 1980.

The VA has authority to provide readjustment counseling services to active-duty military personnel through the mechanism of sharing agreements under Public Law 97-174 or through other interagency "sharing" authority. Therefore, we do not believe that legislative action, such as proposed in this part of section 4 of S. 2269, is needed. We believe that sharing agreements between the VA and the Defense Department could also address the issue of priority to veterans for these services.

Question 29. The reason given for changing the beginning date of the Vietnam era for purposes of Title 38 is to bring the date to the time "that the activities of our troops in Vietnam clearly had begun to expose them to the substantial possibility of being killed by the enemy." With all the conflicts we face in the world of an undeclared nature like Vietnam, I think we need to be careful about our legislative actions. The current Title 38 definition of the Vietnam era is consistent with that of the other two undeclared wars defined in Title 38: Korea and the Mexican Border Period. Why do you support changing this definition?

Answer 29. Between July 8, 1959, the date of the first American military casualty, and August 1964, the date of the Gulf of Tonkin Resolution, approximately 48,000 veterans served in the Armed Services in Vietnam under adverse conditions which can be considered akin to wartime conditions. We believe that these veterans should be granted eligibility for the same benefits that are provided to those who served in that conflict. We believe that this extension of the date of the Vietnam era is consistent with the policy of Congress of providing benefits to veterans who served their country during the Vietnam period. Because the number of veterans made eligible by this provision is not large, we do not believe that the cost of section 2 of S. 2269 would be significant.

Question 30. How would you define ongoing conflicts such as El Salvador? Do we wait for the first casualties or a certain level of involvement?

Answer 30. Section 4 of S. 2269 provides that the term "hostilities" would mean a situation in which the VA Administrator, in consultation with the Secretary of Defense, finds that members of the Armed Forces were subjected to danger from armed conflict comparable to the danger that members of the Armed Forces were subjected in battle with the enemy during a period of war. Should this provision be enacted as written, the VA would coordinate with Defense Department on determining when a period of conflict exists.

Question 31. Why is July 8, 1959 a more appropriate change than a date in 1954 when 342 U.S. military personnel were introduced to assist and train Vietnamese soldiers as part of the U.S. Military Assistance Group, also known as MAAG?

Answer 31. As indicated by the Vietnam Veterans Memorial, the first American casualties began to occur regularly in 1959.

Question 32A. The VA has indicated that an official plan to address health care needs in Puerto Rico will be presented this spring as part of the FY 1986 MEDIPP cycle. When will you, indeed, present an official plan? Will it specifically address services currently delivered under the contract authority?

Answer 32A. The VA released a major study in 1982, and updated that study in December, 1983. The MEDIPP plan for the district which covers Puerto Rico reflects the findings of the study. The VA has not indicated that yet another plan or study is to be released this spring. We have indicated that the decisions resulting from assessment of the MEDIPP plans will be the basis for formulating the agency's budget request for FY 1986.

Question 32B. If the Congress were not to extend the contract authority in Puerto Rico, what options would the VA have to provide care to veterans currently receiving care under that authority?

Answer 32B. If the contract authority is not extended, the medical care needs of a large population of nonservice-connected veterans would go unmet. The existing VA health care facilities could not absorb the demand, and it is impractical to consider utilization of VA health care facilities on the mainland, because of the distance involved. Veteran applicants would be forced to wait their turn for access to these facilities. Medical benefits would be granted according to the priorities presently established by regulation, and within the physical capacity of the facilities. Veterans receiving contract care at the time of expiration of the contract authority would continue receiving care at VA expense until such time as transfer to VA facilities could be made or until the veteran could be discharged from care. No others would be accepted for contract care. Veterans residing in the Virgin Islands who require care for nonservice-connected disabilities would be faced with the same situation, and in addition they are much farther away from the only existing VA health care facility.

Question 33A. The turnover rate among Va police officers for 1982 was 29 percent and for 1983 was 26 percent. In yur opinion, what accounts for the decline?

Answer 33A. We have no opinion as to why our turnover rate declined three percentage points in 1983. The number of replacement officers hired during the first three months of 1984 indicates a projected 27.3 percent annualized turnover rate for 1984.

Question 33B. If a special clothing allowance for VA police were increased, what, if any, impact would this have on the turnover rate among VA police officers: i.e., the turnover rate is now 26 percent. By how many percentage points would you expect it to decline if the clothing allowance increased to $400 per year?

Answer 33B. The increased uniform allowance would relieve an unfair financial burden and enable VA police officers to achieve and maintain a standard of appearance both of which would improve morale. The improved morale and pride in unit and mission could, optimistically, reduce our annual turnover by 3-5 percentage points.

Question 34. The VA has said that most VA police officers are employed at GS-4 or GS-5 salary levels. What is the average salary for VA police officers and how does this compare with salaries of such police officers employed in the private sector?

Answer 34. For police entry level salary comparison purposes on a nationwide basis, the current edition of "A Survey of 1983 Salaries and Working Conditions of the Police Departments in the United States" is used. This publication by the Fraternal Order of Police, 32nd Edition, dated March 15, 1983, provides entry salaries offered by police and sheriff departments serving population groups of all sizes. The average annual wage offered to untrained recruits by police departments serving communities of 10,000 or less persons is $14,368. The trained GS-4 VA police officer enters employment at a salary of $12,367 and the more highly-qualified GS-5 VA police officer enters at a salary of $13,837.

Question 35A. OPM approved VA's request for special pay rates for VA police at VA medical centers at New York, New York; Northport, New York; and Palo Alto, California. How many requests for special pay rates for VA police have been submitted to OPM over the past 5 years and at what specific locations?

Answer 35A. Active records of VACO Personnel on special salary rate requests extend back only to October 1, 1980. Since that date, fourteen separate requests for special salary rates were submitted to OPM. Those are as follows:

1. Four Chicago metropolitan area medical centers (area request).
2. Three New York City metropolitan area medical centers (area request).
3. Dallas, Texas
4. Northport, New York
5. Palo Alto, California

6. Wood, Wisconsin
7. West Los Angeles, California
8. Cleveland, Ohio
9. Houston, Texas
10. Miami, Florida
11. Memphis, Tennessee
12. Montrose, New York
13. Loma Linda, California
14. Dayton, Ohio

Question 35B. How many of these requests were approved?

Answer 35B. The first listed six of the fourteen requests were approved.

Question 35C. What kind of information did you submit to OPM to justify your requests?

Answer 35C. In each request the full documentation required by OPM procedures at the time of the request was provided. This documentation included detailed staffing information, i.e. losses and gains, recruitment times, quits for pay, and special recruitment efforts made. In addition, each request included detailed area salary survey information to reflect differences in compensation offered for like work.

Question 36. In your opinion in order of importance, what are the five most significant factors which affect the ability of the VA to recruit and retain VA police?

Answer 36. The five most significant factors, in order of importance, which affect the ability of the VA to recruit and retain VA police are considered to be:

1. Inadequate basic salary.
2. Inadequate uniform allowance.
3. Lack of upward mobility opportunities.
4. The requirement to rotate shifts to achieve an equitable sharing of workload and experiences.
5. High qualification and performance standards.

Question 37. I understand that completion of preapplications for State Homes grants—such as working drawings and the bid package—await notification of the availability of VA funds for the project. Currently what is the oldest preapplication in the unfunded backlog?

Answer 37. The oldest application for which funds are not now (FY 84) available was received in December 1980.

Question 38. What would be the result of a priority system such as proposed in S. 2269 on the dollar amount of total unfunded grants and the ages of grant requests?

Answer 38. A priority system such as proposed in S. 2269 would not be expected to change the total dollar amount of unfunded applications. Depending upon funds available, criteria established, and priority assigned, some applications might remain unfunded for a number of years or never be funded. Applications receiving a high priority would be expected to have a shorter time between date received and the date of the grant award than under the current system, if the States had the matching funds available.

Question 39. What are the minimum, average, and maximum lengths of time between notification of the availability of VA funds and the completion of an application and award of grants?

Answer 39. The minimum length of time can be 1-6 months after notification that funds are available if the state has made funds available to complete final drawings and specifications approvable by the VA. The average time is 9-14 months. The maximum is 24-36 months when unanticipated problems arise.

Question 40. Please provide a list of the submission dates of each current unfunded request and whether each is for new construction or renovation.

Answer 40.

State (locality)	Project	Date Rec'd	Type
MD (Charlotte Hall)	New State Home (3rd Phase 126 Dom/NH Beds)	5/4/79 .	N
MD (Charlotte Hall)	New State Home (4th Phase 126 Dom/NH Beds)	5/4/79	N
CO (Rifle)	New State Home - 100 NHC Beds	7/16/79	N
NE (Scottsbluff)	50-Bed NHC Wing & Renovations	9/21/79	N
PA (Hollidaysburg)	Boiler Plant Modifications	4/11/80	R
IL (Manteno)	New State Home - 300 Bed NHC	6/16/80	N
IL (Quincy)	Renovation Andrew	8/26/80	R
IL (Quincy)	Energy Conservation	8/26/80	R
NM (T or C)	New Home - 53 Dom, 133 NH Beds	9/9/80	N
CT (Rocky Hill)	Window Replacement	9/24/80	R
IL (Quincy)	Fire Safety	10/23/80	R
IA (Marshalltown)	Renovate Loftus - NH - Life Safety	12/2/80	R
VT (Bennington)	50 Bed NH Care Unit & Renovations	12/11/80	N&R
MI (Grand Rapids)	Replacement of Mann Building - 226 NH Beds	12/12/80	N&R
CA (Yountville)	Hospital Addition - 56 Beds	2/11/81	N&R
CA (Yountville)	Remodel Dom - C	2/11/81	R
CA (Yountville)	Remodel Dom - A	2/11/81	R
CA (Yountville)	Cooling Plant and Piping	2/11/81	R
MI (Marquette)	New State Home 155 - Bed Conv to NH	3/23/81	N
NJ (Paramus)	New State Home - 300 Bed NH	5/11/81	N
MS (Jackson)	New State Home - 150 Bed NH	5/22/81	N

State (locality)	Project	Date Rec'd	Type
MT (Columbia Falls)	50 - Bed NH Wing	6/1/81	N
MA (Chelsea)	Elevators	9/22/81	R
MA (Chelsea)	Renovations	11/6/81	R
CA (Yountville)	Remodel Hospital Ward 1A	11/16/81	R
PA (Hollidaysburg)	Renovations-NHC-Grant Increase	12/11/81	GI
PA (Hollidaysburg)	Renovations-DOM-Grant Increase	12/11/81	GI
GA (Milledgeville)	150 Bed NH	2/1/82	N
MN (Hastings)	Grant Increase	2/5/82	GI
IL (Quincy)	Life Safety-Fire Alarm	4/22/82	R
PA (Hollidaysburg)	Renovation-Sommer-225 NH Beds	6/8/82	N&R
CA (Yountville)	Rem. Sec. B to NH-Life Safety	6/22/82	R
CA (Yountville)	Rem. Sec. D Dom-Life Safety	6/22/82	R
CA (Yountville)	Rem. Sec. E Life Safety	6/22/82	R
CA (Yountville)	Rem. Hospital Support Svc.	1/27/83	R
CA (Yountville)	Rem. Nursing Home	1/27/83	R
CA (Yountville)	Rem. Sec. F - Handicapped	1/27/83	R
CA (Yountville)	Rem. Workshop-Sprinkler	1/27/83	R
NY (Long Island)	New 350 Bed NH	2/16/83	N
CA (Yountville)	Rem. Sec. H Dom-Fire & Safety	3/18/83	R
CA (Yountville)	Rem. Sec. J Dom-Fire & Safety	3/18/83	R
CA (Yountville)	Rem. Sec. K Dom-Fire & Safety	3/18/83	R
CA (Yountville)	Rem. Sec. L Dom-Fire & Safety	3/18/83	R
CA (Yountville)	Rem. Wings 1C-D, 2C-D, 3C-D NH-Fire & Safety	3/18/83	R

State (locality)	Project	Date Rec'd	Type
AR (Little Rock)	Conversion 70 Dom beds to NH	4/20/83	R
PA (Hollidaysburg)	Renovate Dietary Building to serve 427 NH & 179 Dom	5/12/83	R
RI (Bristol)	Domiciliary Renovation	11/6/83	R
FL	New State Home 150-bed Dom	1/19/84	N

***Legend**

N = New
R = Renovation
GI = Grant Increase

Question 41. What complaints have you received which question the need for State Homes projects which have received VA grants? From whom have you received these complaints?

Answer 41. The VA has not received any complaints questioning the need for State Home projects.

Question 42A. How many VA facilities have Incentive Therapy Programs?

Answer 42A. 85 Incentive Therapy; 40 Compensated Work Therapy.

Question 42B. Where are these programs located?

Answer 42B. See attached list.

INCENTIVE THERAPY PROGRAMS

Veterans Administration

(Fiscal Year 1983)

V.A. MEDICAL CENTER

American Lake, WA
Asheville, NC
Augusta, GA
Bath, NY
Battle Creek, MI
Bay Pines, FL
Bedford, MA
Biloxi, MS
Bonham, TX
Brockton/West Roxbury, MA
Bronx, NY
Brooklyn, NY
Buffalo, NY
Canandaigua, NY
Chillicothe, OH
Cincinnati, OH
Cleveland, OH
Coatesville, PA
Columbia, MO
Dallas, TX
Danville, IL
Dayton, OH

VA MEDICAL CENTER

Dublin, GA
Durham, NC
Fort Howard, MD
Fort Lyon, CO
Fort Meade, SD
Fresno, CA
Gainesville, FL
Grand Junction, NE
Hampton, VA
Houston, TX
Iowa City, IA
Knoxville, IA
Leavenworth, KS
Lebanon, PA
Lexington, KY
Little Rock, AR
Livermore, CA
Long Beach, CA
Los Angeles (West), CA
Lyons, NJ
Marion, IN
Martinez, CA

Incentive Therapy Programs (Cont.)

V.A. MEDICAL CENTER

Martinsburg, WV

Memphis, TN

Miami, FL

Montrose, NY

Mountain Home, TN

Mrufreesboro, TN

New Orleans, LA

Northampton, MA

North Chicago, IL

Northport, NY

Oklahoma, City, OK

Omaha, NE

Palo Alto, CA

Perry Point, MD

Pittsburgh (H.D.), PA

Prescott, AZ

Providence, RI

Roseburg, OR

Richmond, VA

Salem, VA

Salisbury, NC

V.A. MEDICAL CENTER

Salt Lake City, UT

San Diego, CA

Seattle, WA

Sepulveda, CA

Sheridan, WY

Shreveport, LA

St. Cloud, MN

St. Louis, MO

Syracuse, NY

Temple, TX

Togus, ME

Tomah, WI

Topeka, KS

Tuscaloosa, AL

Tuskegee, AL

Waco, TX

Washington, DC

White City, OR

Wichita, KS

Wood, WI

COMPENSATED WORK THERAPY

Augusta, Georgia

Battle Creek, Michigan

Bedford, Massachusetts

Biloxi, Missouri

Boston, Massachusetts

Brockton, Massachusetts

Canandaigua, New York

Chillicothe, Ohio

Cleveland, Ohio

Coatesville, Pennsylvania

Danville, Illinois

Hampton, Virginia

Hines, Illinois

Houston, Texas

Knoxville, Iowa

Leavenworth, Kansas

Lexington, Kentucky

Little Rock, Arkansas

Los Angeles, California

Memphis, Tennessee

Montrose, New York

Mountain Home, Tennessee

Murfreesboro, Tennessee

New York, New York

Northampton, Massachusetts

North Chicago, Illinois

Northport, New York

Oklahoma City, Oklahoma

Palo Alto, California

Providence, Rhode Island

Salt Lake City, Utah

San Antonio, Texas

Sepulveda, California

St. Cloud, Minnesota

Tampa, Florida

Tomah, Wisconsin

Topeka, Kansas

Tuscaloosa, Alabama

Waco, Texas

Wood, Wisconsin

Question 42C. How many veterans participated in the Incentive Therapy Program in 1983?

Answer 42C. 30,347 Incentive Therapy; 7,250 Compensated Work Therapy.

Question 42D. What are their primary diagnosis?

Answer 42D. Data not available, however, the majority of patients in Incentive Therapy were either in domiciliaries or had a psychiatric diagnosis.

Question 42E. What were their average lengths of stay in the program?

Answer 42E. One year or less.

Question 43A. What kinds of outcome measures are employed to determine the success of the therapy?

Answer 43A. Success of therapy is determined by the achievements of the therapeutic goal, e.g.,

I. Employment
  A. Pre-Vocational Assessment
  B. Vocational Skills Training
  C. Job Placement
II. Preventive and Maintenance Therapy for Geriatric Patients
  A. Mental Stimulation
  B. Socialization
  C. Support through improved competence and feelings of self worth.
  D. Providing opportunity for maintaining physical well being through physical activity.
    1. Range of Motion
    2. Manual Dexterity

III. Work Restoration for Chronic Psychiatric Patients with Little to no Potential for Vocational Rehabilitation

   A. Providing opportunity for successful experience leading to improvement in confidence and self worth.

   B. Behavior Modification

   C. Purposeful Activity

Question 43B. What percentage of FY 83 program participants had a successful outcome?

Answer 43B. Data not available.

Question 43C. What kinds of follow-up occurs once the program participants complete the program?

Answer 43C. Primary follow-up is maintained on veterans in the program for employment and vocational goals. Follow-up on these programs are usually accomplished through the Case Management program or Psychology Service since they have the major responsibility for job referral and placement.

Question 43D. With what frequency does such follow-up occur?

Answer 43D. As frequently as necessary but no less than quarterly.

Question 44A. What was the average income earned among participants?

Answer 44A. The Compensated Work Therapy budget for FY 1983 was approximately $3,045,934. Of this amount, $2,184,662 was obligated, leaving a balance of $893,154. The average earnings for veterans in this program has little meaning since patients are paid either by piece rate or hourly, depending on the contract and the program. The average amount for geriatric patients would be significantly lower than the average earnings for patients in a vocational/employment readiness program. Therefore, the overall average of $164.38 in Compensated Work Therapy has little bearing on the impact of this legislation or for those veterans who may receive a significant annual income from the program. Within the total number of patients, a certain number may earn as little as $5.00 and be discharged or change programs. The average income earned in Incentive Therapy was $166.37. This, too, is misleading since the majority of all patients in domiciliaries are in the program from one day to one year which could represent a patient earning as little as 50 cents.

Question 44B. What was the average total income of such participants, including pension income during that time period?

Answer 44B. Unknown. This information has not been recorded.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. On page 3 of your statement, you mention the "Information and Referral program" and note that it is "the subject of an Interagency Agreement." Please provide further detail about the Information and Referral Program including a copy of the relevant Interagency Agreement.

Answer 1. The Veterans Administration, through the Department of Medicine and Surgery and the Department of Veterans Benefits, participates in the Information and Referral (I&R) Program at the national and local levels. The program goal is "to stimulate the development and strengthen I&R network systems through cooperative and coordinated efforts of a consortium of federal and public agencies, selected national voluntary organizations and the private sector." (1983 Interagency Agreement, page 3.)

Underlying the purpose of I&R is the concept that through a working knowledge of all services and programs offered in a community, a client can receive the best possible combination of health, social, financial, and other assistance, as needed. In addition, gaps in services for the elderly can be identified and addressed by the community. For the VA, involvement in a community's Information and Referral System provides a positive addition to the array of VA extended care programs and eases appropriate placements into the community where support services are required.

Each VA facility has an I&R representative who maintains a twofold responsibility: (a) to bring information about available community resources to the VA staff on a continual basis, for use in discharge planning and other outplacement processes; and (b) to provide relevant, accurate information about VA services to community agencies. The duties of the I&R representative include, but are not limited to:

- Participating in activities designed to identify and meet the needs of older veterans, such as community planning meetings and outreach activities.

- Encouraging or maintaining I&R mechanisms which integrate veterans into non-VA community settings, such as Senior Citizen Centers, Outreach Adult Centers, service organizations post activities, and other related health and social programs.

- Providing consultation to and sharing knowledge with state, area, and community agencies concerned with the planning and delivery of benefits and services to aging beneficiaries of the VA.

- Maintaining contact and coordinating presentations to community groups with the Department of Veterans Benefits, whenever possible.

- Distributing VA information materials—"Veterans Benefits for Older Americans," "Federal Benefits for Veterans and Dependents, Fact Sheet," and other printed matter—to the local AAA and I&R offices for use and further dissemination.

A copy of the "Working Agreement for the Consortium on Information and Referral Services for Older People" is attached. The VA's action steps for implementing the agreement are listed on page 11.

APR 15 1983

A Working Agreement
for the Consortium
on
Information and Referral Services for Older People

I. Background

In May 1975, a Working Agreement on Information and Referral Services for Older People was negotiated among fifteen Federal Departments and agencies and an Interdepartmental Task Force on Information and Referral established. The Task Force, in response to a Federal directive, was expected to (a) assess the Federal information and referral resources that exist and (b) develop a plan of action designed to improve and coordinate these resources. As a result, the Federal agencies agreed to work in concert to achieve the following objectives:

(1) Improve the information and referral activities of Federal Departments and agencies in order to maximize the efforts of the Federal Government in responding to the needs of older people.

(2) Improve the activities of Federal Departments and agencies to facilitate actions that impact directly on the improvement and coordination of information and referral services at the State, area and community levels.

(3) Monitor and evaluate the progress of Federal agencies' responsiveness to the information and referral needs of older people.

Implementation of the Agreement has contributed to the significant progress in the delivery of information and referral services to older Americans, from the Federal to the local level. Knowledge has been gained about the processes and technologies that are being used to enhance Information and Referral (I&R) services which was transmitted to program administrators and personnel. Task Force efforts have paved the way to improved cooperation between governmental and non-governmental agencies and organizations. Specific Task Force accomplishments are:

- Publication of an I&R Guide which sets forth baseline criteria for I&R services to be judged adequate regardless of organization and scope. The Guide has been distributed to users nationwide.

- Development of a strategy for a local-level pilot I&R workshop with potential for nationwide implementation. Two Statewide I&R workshops were conducted - one in North Carolina and the other in Indiana. Results of the workshop have been described and disseminated to States and Area Agencies on Aging.

- Annual reports which describe yearly projects of the Task Force and the I&R actions of member agencies.

Recent Federal legislative changes and agency reorganizations have resulted in the loss of several agencies which were party to the I&R Working Agreement. As a result, a new agreement and coalition of agencies is necessary to continue collaborative efforts to promote and to improve I&R service delivery -- specifically to strengthen I&R network systems as a more efficient and cost effective means of providing services. A Consortium of Federal agencies and private sector national organizations with a serious interest and/or investment in I&R is being undertaken as a support to States, Area Agencies on Aging and local communities in furthering the development and operation of comprehensive coordinated I&R service systems.

An I&R system is defined as the structure and process for linking people in need with appropriate resources within a given geographic service area. Critical to the system is the cooperative participation of all entities performing the specific I&R functions. The I&R system must involve both horizontal relations (among I&R providers at the same level) and vertical relationships (between I&R providers at different levels). The effectiveness or capacity of an I&R system will be determined by the extent and quality of these relationships.

II. Purpose

Presently a large part of the Federal role is directed at the issues of efficiency and effectiveness in the delivery of human services. There is renewed interest at all levels of government in ensuring that the resources available are being applied in order to obtain the most benefit.

The focus of the Administration is upon issues that cross cut human services such as systems development, resource allocation, measuring quality and cost-effectiveness, and greater private sector involvement.

It is expected that States, Area Agencies and community programs will achieve greatest efficiencies in their operations to seek confirmation that the services and benefits are being directed to programs which are indeed effective. Major change and innovation in social services is likely with a growing trend for expanded private sector involvement and greater integration of local services.

Information and Referral networking is a vital element in meeting the challenge of today's emphasis on systems development, services integration, and responsive and cost-effective service delivery. Within the context of the original objectives of the Interdepartmental Task Force -- to improve services and respond to the needs of the older people - the purpose of this agreement, is to stimulate the development and strengthen I&R network systems through cooperative and coordinated efforts of a consortium of Federal and public agencies, selected national voluntary organizations and the private sector.

III. Implementation Strategies

The Administration is committed to a social service philosophy which holds that when social services are needed, they are best defined and administered at the community level where the most accurate information is available about the nature and extent of the problems and the appropriateness of a variety of resources or solutions. Access to appropriate resources is a continuing fundamental issue facing the service delivery system. Pertinent to the issue of access is the use of I&R and consumer information to enable persons in need to learn of services.

The Working Agreement on Information and Referral Services for Older People will provide a tool to assist States and community agencies in the development of cooperative relationships necessary for effective use of available resources and for coordination of I&R planning and service delivery activities.

Statement of goal:

- o To promote I&R network systems through cooperative and coordinated efforts of the I&R Consortium. To accomplish this goal, it will be necessary --

  1. To provide dialogue and exchange of information regarding I&R and consumer information systems among selected national organizations and Federal agencies, and the private sector.

  2. To identify and encourage dissemination of "best practice" I&R information systems.

  3. To encourage the development of workshops and support participation in national, regional, and local conferences specifically focused upon developing I&R network systems.

  4. To cooperate in the design and implementation of special projects which enhance the development of I&R systems.

  5. To promote the dissemination and utilization of I&R systems standards.

In support of the stated objectives each agency will:

1. provide a representative to actively participate in the functions of the Consortium including -- attending monthly meetings, reporting agency I&R activities to the Consortium, and ensuring the fulfillment of action steps of that respective agency;

2. identify and disseminate available information to its constituency using existing channels of communication such as newsletters, interorganizational memorandum(a), conferences, and workshops; and

3. support the participation in special projects as determined by the Consortium to further the development and operation of I&R systems.

The Information and Referral Consortium action steps are defined more specifically as follows:

The Administration on Aging will:

Provide the Chairman for the Consortium and staff assistance as appropriate.

Provide direction and technical assistance material to AoA Regional Offices to support staff efforts in mobilizing the interest and cooperation of State and Area Agencies on Aging in the development locally of I&R systems.

Transmit to the Network on Aging the concept of an I&R systems approach to the human service delivery network and distribute the AIRS/UWA Joint Standards for I&R systems.

Encourage State and Area Agencies on Aging to support and participate in local efforts and to develop and implement I&R systems.

Encourage the Network on Aging staff to attend and participate in national and local conferences which focus upon I&R issues and the latest developments in the field.

Disseminate data pertaining to I&R systems development and "best practice" information and survey the Network for I&R developments.

The U.S. Department of Agriculture (USDA), Office of Rural Development Policy (ORDP) will:

Continue providing a liaison to work with the I&R Consortium in the implementation of its goals and objectives.

Identify "best practice" I&R information systems, if available, from the rural development strategy responses.

Promote outreach for the rural elderly through the Working Group Members of the Rural Development Committee of the Secretary's Policy and Coordination Council, which represents 15 agencies within USDA and the State Food and Agriculture Councils.

The Alliance of Information and Referral Systems, Inc. (AIRS) will:

Provide Consortium members with written fact sheets and membership information about AIRS.

Make available similar information for distribution to state, regional or local affiliates of Consortium members.

Report to the Consortium on programs and activities of AIRS and its members, i.e.,.

- o Conferences and training opportunities
- o Publications (e.g., newsletters, journals, national directory of I&R programs, papers)
- o Special projects demonstrations
- o Calls for papers

Through the bi-monthly AIRS newsletter, report to AIRS members on programs and achievements of the Consortium.

Make available to Consortium members and their affiliates the AIRS-United Way of America National Standards for Information and Referral and the AIRS program self-evaluation tool, when finalized.

Participate in the design and implementation of special projects undertaken by the Consortium to enhance the development of information and referral systems.

The Department of the Army, Office of the Adjutant General, Army Community Services Division, will:

Promote the dissemination and utilization of national information and referral standards DOD-wide.

Conduct a workshop at the 1983 Army Community Service conference regarding information and referral network/systems.

Identify and disseminate "best practice" information and referral systems through regulations, handbooks, newsletters, and workshops.

Disseminate Army Community Service directories and fact sheets regarding information and referral systems among Consortium representatives.

Disseminate Consortium directories and fact sheets regarding information and referral systems among Major Command Army Community Service representatives.

The Clearinghouse on the Handicapped will:

Through the bi-monthly newsletter, "Programs for the Handicapped", and other publications, provide current information on federal programs, legislation, funding, and publications.

Link providers of services to handicapped individuals (such as independent living centers) with information and referral centers.

Make the availability of the Clearinghouse's "Directory of National Information Sources on Handicapped Conditions and Related Services" known to potential users across the nation. This directory is a major networking tool describing the information services of all major national organizations and agencies serving the disabled population. This publication can also assist in locating information and services for elderly individuals, since resources are listed for many of the conditions which afflict them e.g. arthritis, diabetes, stroke, and hearing and vision loss. The information contained in the "Directory" is available for on-line searching through Bibliographic Retrieval Services.

The U.S. Department of Education, Center for Education Improvement, Division for Library Programs State and Public Library Services Branch will:

Promote and disseminate information on I&R, especially "Best Practice" projects, to the State Libraries throughout the Country and the Territories, through the use of the Information Memorandum system utilized by the Branch.

Promote the dissemination and utilization of national I&R standards within the framework of the public library systems through coordination with and information dissemination to the State Library Administrative Agencies and their staff specialists.

Furnish the I&R Consortium with information on library projects on I&R for the Aging funded under the Library Services and Construction Act.

Disseminate materials from other Consortium members on the topic of I&R to the State Libraries, and encourage them to make such material available to all interested parties within their State or Territory.

Participate in the meetings and the planning of special projects, workshops, or conventions of the I&R Consortium, and to participate in such meetings or conventions as funds allow.

The Department of Housing and Urban Development (HUD) will:

From its Central Office, supply the Administration on Aging for distribution to the Area Agencies on Aging, those HUD issuances pertaining to the elderly as they are published;

Through its Area and Insuring Offices respond to general questions on elderly housing availability, eligibility for occupancy, etc., by Area Agencies on Aging or information and referral centers, or refer questions to specific local sources.

Through local public housing and other HUD assisted projects provide a conduit for information and appropriate materials developed by the Administration on Aging or information and referral centers, and, in some instances, may be able to provide information and referral sites in community space in the projects for the elderly.

Develop and/or continue collaboration with participating Federal agencies at the regional levels.

The U.S. Office of Consumer Affairs will:

Develop and disseminate fact sheets, directories and other materials designed to answer questions regarding consumer, health care and safety issues.

Sponsor workshops, seminars and conferences designed to identify local resources, highlight successful consumer education programs, provide information regarding alternative mechanisms for resolving consumer disputes and teach consumers how to effectively complain when direct attempts to local dealers have failed.

Promote dissemination of "best practice" information and I&R systems through NCOA newsletters and professional and technical membership units.

Provide site for meetings on I&R topics at NCOA's new National Center on Aging.

Assist in the planning of special Consortium projects to improve and support development of information and referral systems.

Provide a liaison to work with the Consortium.

The United Way of America will:

Provide information to the Consortium regarding the networking and program activities of United Way sponsored Information and Referral Services.

Distribute to local United Way I&Rs networking and program information that is provided by Consortium members. This will be accomplished through the use of standard United Way of America communication channels.

A. National Academy for Voluntarism--I&R Roundtable

B. United Way of America Publications and Newsletters

C. Loan Folders

D. Regional and National Conferences

E. Informal Channels

Identify and make available to Consortium members and their affiliates, existing United Way of America resources that can enhance the development of I&R networks.

A. Loan Folders

B. Information and Referral Papers

1. Developing Information and Referral Systems: A Process of Community Organizing

2. Computerizing Information and Referral Services

Coordinate and sponsor major events like "National Consumers Week" April 24-30, 1983. NCW will focus national attention on lifelong consumer education and provide a vehicle for highlighting existing consumer education programs and materials and encourage development or more information programs and materials.

Work cooperatively with Consortium members in developing and implementing special projects which will enhance and improve information and referral services.

Maintain and disseminate to Consortium members resources located throughout the country which can enhance the development of information and referral networks in consumer education and protection, health care and safety.

The National Association for Area Agencies on Aging (N4A) and the National Association for State Units on Aging (NASUA) will:

Assist in the exchange of information regarding information systems as appropriate to the Network of States and Area Agencies on Aging.

Assist in identifying "best practice" examples of effective and efficient I&R information systems utilizing information from the Data Base as well as through individual contacts.

Include "practice" examples of innovative and cost-effective I&R systems in the Point of Delivery.

Invite the Consortium to respond to a call for a session to present a workshop on I&R systems to the 1983 Annual Conference to be held in Washington, D.C. in July.

Disseminate I&R Standards to the Network through the Point of Delivery as appropriate.

The National Council on the Aging will:

Promote the dissemination and utilization of national I&R standards.

Promote workshops at NCOA Annual Conference regarding - developing, improving and coordinating I&R systems.

Present and make available to Consortium, AIRS-United Way of America National Standards for Information and Referral.

Work cooperatively with Consortium members in developing and implementing special projects which enhance and improve I&R networks.

The Veterans Administration (VA) --through the Department of Medicine and Surgery's Central Office, Medical Districts and Medical Care facilities and the Department of Veterans Benefits Central and Regional Office will:

Develop liaisons with State, Area and Community agencies to:

A. Distribute full information to these agencies to assist aging veterans, their dependents and beneficiaries in obtaining all benefits and services to which they may be entitled under laws administered by the Veterans Administration.

B. Inform State, Area and Community agencies of the needs of aging veterans which are not being met because of ineligibility for or nonexistence of benefits and services under laws administered by the Veterans Administration.

C. Assist in the development of and utilize a system of information and referral services with these agencies.

Share specific technical knowledge in the planning, development and operation of services for the aging.

Provide consultation and technical assistance to State, Area and Community agencies providing benefits and services to aging beneficiaries of the Veterans Administration.

Lennie-Marie P. Tolliver
Lennie-Marie P. Tolliver, Ph.D.
Commissioner
Administration on Aging
Department of Health & Human Services

March 9, 1983
Date

Jeanne Diana
Jeanne Diana, Ph.D.
President
Alliance of Information & Referral
Systems, Inc. (AIRS)

March 18, 1983
Date

Willard (Bill) Phillips Jr
Willard Phillips, Jr.
Director
Office of Rural Development Policy
U.S. Department of Agriculture

2/24/83
Date

Major General Robert M. Joyce
U.S. Department of Army

4 Ap. 83
Date

Helga Roth, Ph.D.
Chief
Clearinghouse on the Handicapped
U.S. Department of Education

March 18/1983
Date

Donald J Senese
Donald J. Senese
Assistant Secretary for Educational
Research and Improvement
U.S. Department of Education

5/16/83
Date

June Koch, Ph.D.
Deputy Under Secretary for
Intergovernmental Relations
Department of Housing and
Urban Development

March 23, 1983
Date

Virginia Knauer

Virginia H. Knauer
Special Assistant to the President and
Director, U.S. Office of Consumer Affairs

Mar 21, 1983
Date

Raymond Mastalish
Executive Director
National Association of Area Agencies
on Aging

3/29/83
Date

Daniel H. Quirk
Executive Director
National Association of State Units
on Aging

March 17, 1983
Date

Jack Ossofsky
Executive Director
National Council on the Aging

5/5/83
Date

Sheila B. Plank

Sheila B. Plank
Vice President
Services Outreach Division
United Way of America

March 21, 1983
Date

Harry N. Walters

Harry N. Walters
Administrator of Veterans Affairs
Veterans Administration

MAY 5 1983
Date

Herbert Pardes, M.D.
Director
National Institute of Mental Health

14 Apr 83
Date

Question 2A. With reference to section 4 of S. 2514, which you address on page 5 of your statement:

> If this provision were enacted, what would be the effect in terms of establishing new eligibility for telecaptioning decoders and would there be a difference as between veterans whose deafness is service-connected and those whose is nonservice-connected?

Answer 2A. Enactment of S. 2514 as drafted would not appear to establish any new eligibility for telecaptioning Television decoders, or any other device for the hearing impaired. Section 4 of the bill would simply amend the definition of "medical services" in 38 U.S.C. § 601(6) to clarify that such devices may be provided to veterans as a medical service. Eligibility for medical services for both service-connected and nonservice-connected veterans is governed by 38 U.S.C. §§ 610 and 612. Those two sections, which now require, among other things, that there be medical need for any medical services provided, would not be amended. Arguably, the enactment of this provision could trigger reevaluation within the DM&S of the circumstances under which such devices would be deemed medically necessary.

Question 2B. How many veterans are receiving compensation or pension from the VA on the basis of being "totally deaf"?

Answer 2B. The Department of Veterans Benefits Schedule for Rating Disabilities (38 C.F.R. Part 4) does not provide a rating specifically for "total" deafness. Rather, veterans with "total" deafness are included among those rated as having "profound" hearing loss, i.e., rated 80% disabled under diagnostic code 6277 (38 C.F.R. 4.87a). Currently, there are 2.433 veterans receiving compensation under that code and there are 340 veterans receiving pension whose major disability is "profound" hearing loss. To determine which of these are "totally" deaf would require a review of the individual veterans' medical records.

Question 2C. How many veterans in addition to those listed in response to subquestion B above does the VA estimate are "totally deaf"?

Answer 2C. The VA has no information on which to base a reliable response to this question. However, a survey conducted of our medical centers several years ago of "totally" deaf veterans identified only 20 veterans suffering from this disability.

Question 2D.	The DAV, in testimony prepared for this hearing, recommends using the term "profoundly deaf" rather than "totally deaf". Please comment, as a technical matter, on the difference between these two terms.
Answer 2D.	A "totally deaf" individual is unable to recognize the presence of any sound. This individual usually has been deaf from birth or has acquired a hearing loss that is the result of the complete destruction of the inner ear. In some instances, a total deafness can be attributed to continued use of ototoxic medication that has been given as a life support, knowing that the person's hearing acuity will be permanently damaged. It is the latter instance that is found most often in the veteran population. A "profoundly deaf" individual is able to recognize the presence of some sounds in his or her environment but will have considerable difficulty in understanding or discriminating what these sounds might be. An individual with a profound loss may or may not be able to receive assistance with hearing through the use of a hearing aid or other assistive devices. The type or amount of assistance that the "profoundly deaf" individual should receive can only be determined through the use of professional audiological evaluations. Because of the difference in definitions, it is more proper to refer to the veteran population as being "profoundly deaf" rather than "totally deaf."

Question 2E. If the term "profoundly deaf" were used in lieu of "totally deaf" how would that change your answers to subquestions B and C above?

Answer 2E. See answer to 2.B. and 2.C.

Question 2F. What is the average cost to purchase and install a telecaptioning decoder and is there any estimate of ongoing maintenance or repair costs?

Answer 2F. The average cost to purchase and install a telecaptioning decoder is $270. At the present time, there is no record of maintenance or repair costs for this device. The device is solid state and would demand little or no maintenance. The earliest issue of a telecaptioning decoder known was approximately three years ago and there has been no need to provide repair or maintenance on this unit.

Question 3A. With reference to the provisions in S.2269 and Amendment No. 2850 relating to VA security personnel,

> Please provide a summary of the limits for petty offenses currently available under the law enforcement regulations of other agencies.

Answer 3A. The U.S. Postal Service has statutory authority to affix penalties for violations of regulations up to a limit of a $50 fine and/or thirty days imprisonment. The authority to affix penalties up to a limit of a $500 fine and/or six months imprisonment is vested in the General Services Administration, the National Park Service, the Forest Service of the U.S. Department of Agriculture, and Walter Reed U.S. Army Hospital.

Title 18 of the United States Code - Crimes and Criminal Procedures, Section 1(3) defines a petty offense as "any misdemeanor, the penalty for which does not exceed imprisonment for a period of six months or a fine of not more than $500, or both." As a result, several U.S. District Courts have established these penalties in their Rules of Court for trials of petty offenses as applicable to all Federal agencies except those with lower limits established by statute.

Question 3B.	With reference to the provisions in S. 2269 and Amendment No. 2850 relating to VA security personnel, Please provide technical assistance, in conjunction with the Department of Justice, on any needed clarifications of the proposed new section 218(b) of title 38, as would be necessary or appropriate to carry out the intended purpose of clarifying the authority of VA police officers to enforce laws and regulations to make arrests, especially the standards governing when such arrests could be made.
Answer 3B.	Amend subsection 218(b) as proposed in Amendment 2850 to S. 2269 to read as follows: (b) The Administrator may designate employees of the Veterans' Administration as Veterans' Administration Security Service officers. Such officers shall enforce Federal laws and the regulations prescribed under subsection (a) of this section, on Veterans' Administration property. Any Veterans Administration Security Service officer may make an arrest, with or without a warrant, of any individual on Veterans' Administration property, or any individual who is fleeing Veterans Administration property, after the commission of an offense by such individual if (1) such offense occurs in such officer's presence, or (2) such officer has reasonable grounds to believe (A) that the offense constitutes a violation of any law of the United States or of any regulation prescribed under subsection (a) of this section, and (B) that the person be arrested has committed that offense.

Question 4. Don, in light of the statement in your February 22 letter to me that "there is less than unanimity among (V.A.) psychiatric staff as to the desirability of (P.T.S.D. inpatient) units," I was quite surprised to see your statement on Page 17 that the V.A. is "encouraging the development of P.T.S.D. programs" at V.A. medical centers. As you know, I wrote you on March 23 seeking further information on the overall issue of the V.A.'s efforts on P.T.S.D., and I'll wait for your response to that letter to get a more complete picture of what's going on. However, I would appreciate it if briefly now, and in more detail for the record, if you could describe what steps are underway at present "to encourage" the establishment of P.T.S.D. units and what success you are having as a result of these efforts.

Answer 4. The Veterans Administration recognizes that Vietnam veterans with post-traumatic stress disorder need a broad spectrum of services. Vet Centers provide part of this spectrum of services, furnishing readjustment counseling, family counseling, job assistance, and referral for other needed services. Veterans Administration medical centers and clinics provide other needed services such as individual psychotherapy, alcohol treatment, inpatient psychiatric treatment for associated psychiatric conditions, and inpatient treatment for post-traumatic stress disorder.

In a vigorous and healthy medical care system, there are differences of opinions concerning the best method of treatment for a particular condition. There are constructive differences of opinion among Veterans Administration mental health professionals about the best approach to the treatment of post-traumatic stress disorder. From these professional differences, frequently emerge improved understanding and new treatment approaches. The Veterans Administration Central Office has no intention of cutting short these discussions by issuing directive guidance to mental health professionals concerning the Central Office view of post-traumatic stress disorder.

Nevertheless, the Mental Health and Behavioral Sciences Services has been having frequent discussions with VA medical centers concerning development of treatment programs for post-traumatic stress disorder utilizing both inpatient and outpatient treatment approaches. Proposals for such programs are under active consideration at VA medical centers in Massachusetts, Connecticut, New York, Pennsylvania, Ohio, Georgia, Florida, Kansas, Texas, Arizona, California, Oregon, and Washington.

Programs based upon local program initiatives are consistent with my philosophy on decentralized program planning. Programs developed on local bases utilize local skills and talents, and recognize local treatment needs more effectively than programs developed on a centralized basis.

Central Office is encouraging the development of post-traumatic stress disorder programs in a variety of ways. These include: (1) a request through the MEDIPP process for each medical district to evaluate its need for post-traumatic stress disorder treatment units; (2) VA Central Office staff members from Mental Health and Behavioral Sciences Service and Readjustment Counseling Service are actively participating in Regional Medical Educational Center (RMEC) programs on post-traumatic stress disorder treatment; (3) Mental Health and Behavioral Sciences Service has actively encouraged the development of proposals at individual medical centers; (4) further encouragement has been provided for the development of inpatient treatment units for inpatient post-traumatic stress disorder by removing post-traumatic stress disorder from the Diagnosis Related Groups (DRG) base resource allocation method currently in use. This change will eliminate any financial disincentives which might exist for the development of treatment programs whose length of stay is longer than average.

The result of these efforts, as I have indicated, has been the development of increasing interest by VA medical centers in establishing treatment programs for post-traumatic stress disorder. Our success at implementing these programs, as you know, will be directly related to resource issues. Veterans Administration psychiatric services are operating at or near capacity in almost every location. In addition, existing psychiatric programs have significant resource needs. The development of new program initiatives within existing resources requires careful, painstaking balancing of priorities.

Question 5. With respect to automobile adaptive equipment, after reviewing your testimony and that of all the veterans organizations, I think a compromise result might well be to permit an eligible veteran to receive two VA equipment adaptations in any three-year period as part of which the veteran would also be permitted to maintain a second VA-adapted vehicle for backup purposes. Please comment on this approach as an alternative to the approach in S. 2210 limiting assistance to one in three years (subject to case-by-case exceptions) and thus permitting a backup vehicle only after the veteran has had the adapted vehicle for three years. It seems preferable to me to permit more latitude in terms of acquiring a backup vehicle.

Answer 5. While we do not believe that there is a significant amount of abuse attributed to early vehicle replacement, nevertheless, past audits and program evaluations have revealed some instances where veterans have sought reimbursement for adaptive equipment more frequently than might have been essential. Therefore, we believe that a somewhat more restrictive policy than the existing three vehicles in two years limitation is appropriate. We support S. 2210, but, as we stated at the hearing, we strongly recommend that it be amended to provide a one-vehicle-in-two-year restriction. Such a limitation would allow sufficient flexibility to insure that eligible disabled veterans have dependable transportation. A one-vehicle-in-two-year limitation would also allow the veteran to keep and maintain a backup adapted vehicle after the first vehicle is only two years old. We do not believe that a two-vehicle-in-three-year restriction is necessary to meet the needs of eligible veterans and we do not support such an approach.

Question 6. Dr. Custis, in testimony before our Committee on June 20, 1982, you testified as follows:

> In the first case, I should like to put forward what I believe is a new approach to VA-community interaction. It is based on the evident fact that all the statistics I have cited to you confined as they are to veterans as actual and potential patients in our system, may seem to bypass the fact that America is "graying." The issue of an aging population and what means exist or must be created to deal with it creates a set of problems for society as a whole.
>
> It seems to me that we must begin to work with communities all over this country in a variety of ways that recognize that we are a part of the problem (albeit a large part, with an estimate that 60% of all males over 65 in 1990 will be veterans.) It should follow then, that we are only a part of the solution. I think we should, on a local basis, begin to participate in the creation of structures to deal with overall problems of an aging population, some of whom are veterans, so that we can work together with the communities to get the best "bang" for both their "bucks" and ours.

I believe the emphasis on the "creation of structures" to promote VA/community cooperation is very important.

A. In the VA's judgment, would the new section 4120 of title 38, proposed to be added by section 2 of S. 2514, provide the VA with necessary new authority to establish such new "structures"?

Answer 6A. It is not clear that this provision provides the VA any enhanced authority, although Senator Simpson's comments in the Congressional Record express such an intent.

Currently the VA provides referral services which are routinely furnished by various personnel, including nurses and social workers at all VA medical centers. This activity, which comes under the umbrella of the Information and Referral Program, is in consort with an existing interagency agreement involving the Administration on Aging and 14 federal agencies, including the VA. We see no need for legislation which would simply provide authority for ongoing activities.

Question 6B. (If no) As a technical service, please provide draft language that would provide such new authority.

Answer 6B. In June 1982, the Chief Medical Director presented in testimony before the committee a very general concept suggesting the desirability of VA's participating on the local level in the "the creation of structures" to deal with common problems facing an aging population. That concept could be developed in many different ways. At this time, the Agency has not developed a blueprint for implementing the concept. Accordingly, we have no basis to furnish "technical" assistance, as requested.

Question 7. On page 3 of the VFW's statement, in commenting on section 6 of S. 2514 which would require the VA to report on certain VA programs for terminally ill and other veterans, the VFW notes that the agency lacks clear statutory authority to provide "respite care." For the record of today's hearing, please provide:

A. An analysis of the desirability of having such authority and, if such authority were provided, an analysis of how it would be utilized with specific reference to (i) differences between veterans with service-connected conditions and those with nonservice-connected conditions, (ii) whether a period of institutionalization should be required prior to a veteran being eligible for respite care and, if so, how near in time to the respite care institutionalization should be, and (iii) where respite care should be provided (i.e., acute or intermediate hospital bed units or in nursing home care units or all of them); and

B. A description of current respite care activities presently underway throughout DM&S.

Answer 7A. Legislative authority to provide respite care would permit the VA to admit veterans on a planned and prearranged basis according to the needs of the caregiver. The use of respite care prolongs the ability of the caregiver to maintain the ill or disabled veteran at home, and is considered to be an effective therapeutic option in the overall management of the patient and integral to quality patient care. Veterans placed in the community under VA outpatient programs such as Hospital Based Home Care, Spinal Cord Injury (SCI) Home Care, Home Dialysis, Day Hospital, and Day Treatment Centers provide an identifiable target population for respite utilization. Since these veterans are closely monitored during their treatment episode and frequent contacts are made with the caregiver, plans can be made by the treatment team when the need for respite care arises.

So that veterans with service-connected conditions would be accorded the highest priority for respite care, admission could be based on the same priorities currently utilized for hospitalization.

If respite care was authorized for those veterans residing at home with a caregiver and enrolled in one of the VA's noninstitutional health care programs other than outpatient clinical care, for which a period of institutionalization was a requisite, then there would be no need for a separate requirement for a prior period of institutionalization to receive respite care.

The bed location for providing respite care would depend upon the needs of the veteran and the availability of beds. Currently, intermediate care hospital beds would most probably be the principal location, although in some medical centers nursing home care beds and acute care hosp'tal beds would be used, particularly if the patient's needs so indicated.

Answer 7B. While there is no formal VA policy on respite care, limited activity is underway. Seventeen of thirty Hospital Based Home Care Programs provide respite care in various bed sections of the medical center and Nursing Home Care Unit. Three Nursing Home Care Units are implementing a Respite Program with a written policy statement. Respite care is an integral aspect of mental health care and is a continuing practice in our 40 predominantly-psychiatric hospitals.

Question 8. With reference to section 3 of S. 2269 which, as you know, would authorize the VA in situations in which the VA was providing mental health counseling and other services to a veteran's family to continue to provide such services for up to six months to the surviving family members after the veterans death. Please provide the following information:

- the relationship of such post-death or bereavement counseling to a program of hospice care;

- an estimate of the number of family members who might be eligible for such services in a year;

- an estimate of the annual cost of the exercise of this new authority; and

- a description of the extent to which and the circumstances under which the VA currently provides counseling to veterans' family members and the statutory authority for doing so.

Answer 8. Post-death or bereavement counseling is an integral part of a program of hospice care, since the patient and family members are considered to be the unit of care. Family members are consulted and included in the development of the patient's plan of care. As the disease process follows its natural course, family members are sustained with emotional support and counseling by the hospice staff. Following the death of the patient, bereavement counseling to surviving family members is provided and is recognized to be an important restitution component of a Hospice Program.

The FY 1983 data of the Palliative Treatment Program (PTP) at the West Los Angeles VA Medical Center indicate that 88% of the patients receiving hospice care had families. Of the surviving family members, 28% were enrolled in bereavement counseling, which is available at the PTP as an outpatient program. The need for this service is based upon the medical judgement of the hospice physician.

In FY 1982, over 91,000 patients with a malignant neoplasm were treated in VA medical centers. Of those patients treated, about 14,000 died in the hospital. While all of these patient/families are potentially eligible for hospice care, it is recognized that only a portion would choose that mode of care. We estimate that 50% (7,000) would select hospice care but that 12% (840) of the patients would not have family members. We also estimate that 28% (1,725) of the surviving family members would enroll for bereavement counseling sessions. The need for bereavement counseling resulting from a suicide is judged to be for a few isolated instances and would not impact upon our estimates.

Additionally, during FY 1983, 336 patient deaths occurred in the home under the care of the 30 Hospital Based Home Care programs. During FY 1985-9 it is estimated that 550 patient deaths will occur per year in the home under the care of the 49 present HBHC programs. It is estimated that 28% of the surviving family members would avail themselves of bereavement counseling.

In estimating the annual cost of bereavement, it is recognized that some patients do not have families or families who would not choose to receive bereavement counseling from the VA. Based upon one visit per month to the medical center per family during a six month period, the annual cost will not be significant. The increased workload is not considered of a significant magnitude to warrant additional personnel.

In the HBHC Program, the surviving family members would be provided bereavement counseling at the medical center.

Bereavement counseling is currently made available to surviving family members at the Palliative Treatment program of the West Los Angeles VA Medical Center. A 1981 survey of VA medical centers and independent outpatient clinics indicated that about 60 percent of the respondents provided some type of counseling, including bereavement counseling. Ninety-four percent of the families received the bereavement counseling from the medical center chaplain. While there is no specific statutory authority for bereavement counseling, the chaplains provide the counseling under their broad mandate to meet the spiritual and restitutional needs of the patient and family.

The Veterans Omnibus Health Care Act of 1976, P.L. 94-581, dated October 21, 1976, authorized the Veterans Administration to furnish, on an outpatient basis, consultation, professional counseling, and mental health services to members of the immediate family, or legal guardian or the individual in whose household the veteran certifies an intention to live. These professional mental health services may be authorized when considered essential to the effective treatment and rehabilitation of the veteran. This treatment option is essential in order to provide the full spectrum of services necessary for treatment and rehabilitation of the veteran. These outpatient services extend those originally authorized under P.L. 93-82. The following conditions apply under which these outpatient services are provided as a necessary part of treatment:

a. A veteran hospitalized in a VA health care facility or in a non-VA medical facility at VA expense.

b. A veteran receiving outpatient treatment for a service-connected disability.

c. A veteran receiving outpatient treatment for a nonservice-connected disability, where these family mental health services were initiated during the veteran's hospitalization and the provision of such follow-up services on an outpatient basis was essential to permit the discharge of the veteran from the hospital.

Furthermore, readjustment counseling and other services authorized by Public Law 96-22 may be provided to the immediate family members or legal guardian of a Vietnam-era veteran if essential to the effective treatment and readjustment of the veteran.

It has long been recognized that the family constellation and significant other persons play an essential and often critical role in the recovery and community adjustment of patients with mental and readjustment problems. This may involve the direct counseling and treatment of the other person, the establishment of understandings and responses to the patient's behavior or treating the family as a social-psychological entity.

The behavioral adjustment and psychological stability of those in the close interpersonal environment of the veteran are often as important a determinant of the veteran's recovery and rehabilitation as his medications or individual psychotherapy.

As special training and expertise in the provision of family therapy and counseling are required, the function is performed by qualified mental health professionals. Mental health professionals have specialized training in family therapy systems and methods. The mental health professionals assigned to this function are administratively placed within their respective services in the hospital and have a professional assignment to that mental health program which is most appropriate for providing this outpatient family service. This will usually be the Mental Hygiene Clinic, Day Hospital, or a Substance Abuse Program.

There is no statistical data bank that we are aware of which relates to the number of such services provided to veterans' family members.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. STROM THURMOND, A U.S. SENATOR FROM THE STATE OF SOUTH CAROLINA

Question 1. Dr. Custis, do you have any figures on how many veterans who are in receipt of pension benefits are earning wages in Incentive Therapy programs, or sheltered workshops?

Answer 1. During Fiscal Year 1982, there were 1,050 patients in the 41 VA Comprehensive Work Therapy programs who were nonservice-connected veterans receiving a pension. During that same year, 6,461 patients who were in the Incentive Therapy program were nonservice-connected veterans in receipt of a pension. We have recently received statistics from VA medical centers participating in these programs on veterans who were involved in the programs. We are trying to determine from these figures the number of veterans receiving pensions who are also wage earners.

Question 2. Do you know the average earnings of veterans in these programs?

Answer 2. The Compensated Work Therapy budget for FY 1983 was approximately $3,045,934. Of this amount, $2,184,662 was obligated, leaving a balance of $893,154. The average earnings for veterans in this program has little meaning since patients are paid either by piece rate or hourly, depending on the contract and the program. The average amount for geriatric patients would be significantly lower than the average earnings for patients in a vocational/employment readiness program. Therefore, the overall average of $164.38 in Compensated Work Therapy has little meaning. Within the total number of patients, a certain number may earn as little as $5.00 and be discharged or change programs. The average income earned in Incentive Therapy was $166.37. This, too, is misleading since the majority of all patients in domiciliaries are in the program from one day to one year which could represent a patient earning as little as 50 cents.

Question 3. Has the VA taken a position regarding the exemption of income from Incentive Therapy programs in computing pension benefits?

Answer 3. The VA has not at this time taken a formal position on the merits of this proposal.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON.
RUDY BOSCHWITZ, A U.S. SENATOR FROM THE STATE OF MINNESOTA

Question 1. The Senate, led by Senators Cranston and Simpson, has a clear record of support for allowing a delimiting date extension because of alcohol or dependence -- why does the VA continue to cling to its belief these dependencies are willful misconduct?

Answer 1. With regard to Senator Boschwitz's first question, we have enclosed a "white paper" on alcoholism and drug abuse conditions, vis-a-vis VA monetary benefits, which we prepared in August 1982, as a technical service for the Committee, in response to similar inquiries raised at that time. This "white paper" relates the historical development of the law, regulations, and Agency policy concerning alcoholism and other drug dependency conditions as "willful misconduct". It also discusses the serious administrative problems and potential impact of proposed amendatory legislation being considered in this area.

The VA's position on "willful misconduct", as more fully detailed in the enclosed document, has not changed. Moreover, we would point out that the Congress, in enacting the provision for delimiting date extension based on disability, clearly expressed its intent that the VA adhere to its existing regulations and policy on alcohol and drug abuse conditions when implementing the "willful misconduct" bar included in such legislation. We consider ourselves bound by, and have consistently followed, this congressional mandate.

Question 2. Is the VA willing, with this Committee, to put together an administrative or legislative remedy to the GI Bill delimiting date issue that takes into account the VA's fears of being forced to expand the disability compensation program in later years

Answer 2. In the course of previous attempts by the Senate to initiate and have enacted amendatory legislation in this area, this Agency responded to a request by the Senate Veterans' Affairs Committee for assistance in addressing certain shared concerns. Unfortunately, we did not then find such concerns susceptible of satisfactory resolution. Nevertheless, in response to Senator Boschwitz's second question, we again will be pleased to cooperate with the Committee and provide any technical assistance requested.

Question 3. How many veterans have been denied an extension because of the "willful misconduct" criteria?

Answer 3. Please note that the Veterans' Administration has, for some time now, maintained statistics on a fiscal year basis concerning requests for extensions based on disability. However, these statistics (see enclosed copy of fiscal year 1983 report) reflect only the numbers of chapter 34 and chapter 35 requests for extension approved and denied. Unfortunately, neither the compiled fiscal year reports, nor the regional office reports from which statistics for the former are drawn, identify the underlying reason for denial (e.g., "willful misconduct") as to any claims reported in the "denied" category. Consequently, we do not have data reasonably available to us with which to respond to this question.

AUG 11 1982

ALCOHOLISM AND DRUG ABUSE - VA BENEFITS

A. Background

Under various Federal statutes, the Veterans Administration [VA] is proscribed from paying certain gratuitous benefits where disability or death is due to the individual's "willful misconduct." The proscription extends to compensation for service-connected disabilities [38 U.S.C. § 310], pension for disabilities which are not service connected [38 U.S.C. § 521(a)], education benefits payable under an extension of the applicable delimiting period [38 U.S.C. § 1662(a)(1)], and dependency and indemnity compensation for survivors of veterans [38 U.S.C. § 410]. Current VA regulations define willful misconduct at 38 C.F.R. § 3.1(n). The regulations by which alcoholism and drug usage are labelled willful misconduct are 38 C.F.R. § 3.301(c)(2) and (3).

The statutory forerunners of the disability benefit programs also contained a prohibition on payments for disabilities which resulted from willful misconduct. In the context of those laws, the Administrator of Veterans Affairs was required in 1931 to determine whether the drinking of certain beverages was within the willful misconduct bar to benefits. Administrator's Decision No. 2, March 21, 1931, established the rule that drinking excessively any beverage to enjoy its intoxicating effect will be considered willful misconduct where such consumption results in disability. Drinking of alcoholic beverages by itself is not willful misconduct.

The 1931 Decision was incorporated into VA regulations and remained in effect until a modification in 1964. Administrator's Decision No. 988, August 13, 1964, made a distinction between disabilities which are the primary result of drinking alcoholic beverages and those which are the remote, organic, secondary effects. The former, acquired when an individual willingly achieves a drunken state and undertakes a task for which he or she is physically or mentally unqualified (such as driving an automobile while intoxicated), are said to be due to willful misconduct. Disabilities acquired as the secondary result of the chronic use of alcohol were no longer included in the willful misconduct category because they were not considered to be the usual and probable effects of drinking alcohol and, because of their insidious development, were not reasonably foreseen by the individual. That is, even though alcohol may have been consumed over long periods to experience the intoxicating effects, the individual would not have expected or willed the diseases or disabilities which sometimes appear as the secondary effects of that consumption. Under A.D. 988, the remote, organic, secondary effects of chronic alcohol use were excluded from the definition of willful misconduct. The same criteria were applied to the proximate and secondary effects of drug usage.

The two Administrator's Decisions just referred to have formed the basis for the Agency's regulations on willful misconduct as it relates to alcoholism and drug usage. The regulations, 38 C.F.R. § 3.301(c)(2) and (3), state:

> Alcoholism. The simple drinking of alcoholic beverage is not of itself willful misconduct. The deliberate drinking of a known poisonous substance or under conditions which would raise a presumption to that effect will be considered willful misconduct. If, in the drinking of a beverage to enjoy its intoxicating effects, intoxification results approximately and immediately in disability or death, the disability or death will be considered the result of the person's willful misconduct. Organic diseases and disabilities which are a secondary result of the chronic use of alcohol as a beverage, whether out of compulsion or otherwise, will not be considered of willful misconduct origin.
>
> Drug usage. The isolated and infrequent use of drugs by itself will not be considered willful misconduct; however, the progressive and frequent use of drugs to the point of addiction will be considered willful misconduct. Where drugs are used to enjoy or experience their effects and the effects result proximately and immediately in disability or death, such disability or death will be

> considered the result of the person's willful misconduct. Organic diseases and disabilities which are a secondary result of the chronic use of drugs and infections coinciding with the injection of drugs will not be considered of willful misconduct origin. Similarly, where drugs are used for therapeutic purposes or where use of drugs or addiction thereto, results from a service-connected disability, it will not be considered of misconduct origin.

As the regulations are applied by the VA, alcoholism and drug usage are considered to be willful misconduct unless caused by a separate neuropsychiatric disability.

In recent years the VA has been criticized for labelling alcoholism and drug usage as being due to willful misconduct and not recognizing them as disease entities for purposes of the benefit programs. Moreover, the Agency is involved in litigation which challenges VA policy on alcoholism as "willful misconduct" on the basis that such policy does not accurately reflect current medical, scientific or societal attitudes toward habitual and excessive use of beverage alcohol, commonly called alcoholism. See Finnigan v. Nimmo, C.A. No. 4-81-547, D. Mn. (filed August 17, 1981).

B. ISSUES

The initial hurdle in any consideration of paying benefits based on an alcohol or alcohol abuse condition is definitional.

What is alcoholism? What is its cause? What are its effects? How are these determined?

Although considerable study into the nature and causes of alcoholism has been underway for some time, there remains a lack of agreement as to whether alcoholism is a single disease or a symptom of a disease, and whether it has a single cause.

Another issue is the approach to alcohol or drug dependence or abuse conditions in the context of meeting the objectives underlying the various VA programs.

As is evident from examination of chapter 17 of title 38, United States Code, Congress has established wide-ranging medical treatment programs for veterans. Eligibility for care under this system is not statutorily predicated upon whether the condition which requires treatment was "innocently" acquired, as is the case with eligibility for monetary benefits, but rather is determined in part by the individual's ability to obtain needed medical services elsewhere. Thus, any veteran who requires hospital treatment for alcoholism and who cannot defray the cost of private care may, under 38 U.S.C. § 610(a)(1)(B), be admitted to a VA facility. Similarly, a veteran at age 65 may obtain VA hospital care for alcoholism without regard to its etiology. 38 U.S.C. § 610(a)(6). There is no provision in chapter 17 similar to the "willful misconduct" language used by Congress as a basis for non-entitlement to monetary benefits, and, therefore, it is not necessary to evaluate the origin of a veteran's disability before medical care is rendered.

Chapter 17 contains a definition of "disability" at 38 U.S.C. § 601(1) for use in determining which conditions qualify for medical care from the VA. This represents Congressional recognition that physical or mental infirmities which are not compensable under the benefits programs may, nonetheless, require appropriate medical treatment which is not available to veterans from other sources. For example, an individual who has sustained injuries in the course of committing a criminal act is not foreclosed from obtaining medical care from the VA, despite the "willful misconduct" origin of his disabilities for benefits purposes.

Throughout the VA system, benefits and medical care determinations are made separately. Many persons receive health care from the VA even though they are not in receipt of monetary benefits and have been found not to have qualifying disabilities under the various benefits programs. In short, Congress has established different eligibility criteria for the monetary benefit and medical treatment programs which it created, attaching the criteria of "willful misconduct" only to the monetary benefit category of programs. The VA has implemented each type of program according to the statutory mandate despite results which superficially may appear to be internally inconsistent.

The specific issue of alcoholism and drug usage as "willful misconduct" was presented in the context of the GI Bill educational benefit program with the 1977 amendment to 38 U.S.C. § 1662, adding provisions for extension of the delimiting date based on disability which prevented course pursuit during the otherwise applicable delimiting period (Pub. L. No. 95-202, section 203). That statute incorporated the limitation that eligibility could not be based on a disability which was the result of "willful misconduct." Moreover, the legislative history of such provision expressly mandated that the VA, in determining "willful misconduct" for such purposes, use the existing Agency regulations and policy applicable to other VA programs. [See S. Rept. 95-468, 95th Cong. 1st Sess. 69-70 (1977).]

The effect of this congressional limitation has been to bar extensions in cases where the claimed disability is alcoholism or drug usage.

Subsequent to enactment of the delimiting date extension amendment to 38 U.S.C. § 1662, bills have been introduced which included amendments to provide that alcoholism and drug dependence without secondary effects shall not be considered willful misconduct. Two of these passed the Senate: H.R. 5288, as amended (January 24, 1980), and H.R. 3499, as amended (June 16, 1980). Congress, however, has consistently declined to enact such provisions.

A more recent proposal to amend section 1662 with regard to alcohol and drug disabilities has been submitted by Senators Cranston and Simpson as part of an amendment to a currently pending bill (S. 2747). This proposal would permit delimiting date extension if the veteran was prevented from pursuing a program of education or vocational rehabilitation because of an alcohol or drug dependence or abuse condition from which the veteran subsequently recovered, regardless of whether the condition was the result of the veteran's willful misconduct.

In explaining the above-referenced proposal, Senator Cranston, as he did with a prior version in 1977, states that denying extensions to veterans with alcohol or drug dependence or abuse conditions serves no substantial purpose and that, in fact, extending assistance would have a salutary effect on the rehabilitation of certain veterans. However, he notes that, by contrast, undesirable consequences could flow from applying a similar rule for purposes of other VA benefits programs:

> If an individual were to be granted disability compensation for alcoholism or drug addiction, there would be a strong financial incentive established--in the form of a higher rate of compensation or the continuation of receipt of compensation--toward the worsening or prolongation of the disability. Either of these factors are to some extent within the control of the veteran because they depend upon the amount,

frequency, and duration of his or her consumption of alcoholic beverages or drugs.

[128 Cong. Rec. S 8841-2 (daily ed. July 21, 1982)]

Senator Cranston concludes that removal of "willful misconduct" as a consideration in determining entitlement to extension of educational benefit use, in cases involving alcohol or drug dependence or abuse conditions, is fully consistent with readjustment and rehabilitation goals. See Id.

C. Practical Policy and Administrative Problems

Senator Cranston suggests that Congress, by adopting his proposal to extend delimiting dates based on alcoholism or drug abuse, would not intend to undercut administrative or legislative provisions respecting determination of whether such conditions are necessarily the result of "willful misconduct." Id.

The practical consequences of any such congressional action, however, may be quite different. Certainly, such action could be construed as a "statement" by Congress signalling just the opposite intent. In other words, it would be unrealistic to assume that Congress acted in a vacuum--that it simply avoided and did not address the willful misconduct issue. And by not addressing the issue, Congress would leave the clear implication that "willful misconduct" is not a factor in alcoholism or drug usage cases--that it is immaterial. This creates some conceptual problems.

There are three policy objectives inherent in the statutory use of a "willful misconduct" bar: (1) as a matter of public policy, preventing one from profitting from one's own wrongdoing, (2) preventing program abuse, and (3) defeat of the purpose for which enacted. Reasons may be conceived why the latter may not be of significant concern in the context of extending a delimiting date based on disability. See 128 Cong. Rec. S 8841-2, supra (Statement of Senator Cranston). Yet, how can one be permitted to profit from one's own misconduct for purposes of one type of benefit (e.g., educational assistance) and not another (e.g., disability compensation). This presents the paradox that a particular condition (e.g., alcoholism) is considered the result of "willful misconduct" only for certain purposes.

Further, the practicalities of administering the legislative proposal permitting extension of a delimiting date based on alcoholism or drug usage clearly demonstrate the potential for abuse. This concern derives from problems of definition and proof. The former have been previously discussed. As to the latter, there are problems of determining the period during which the veteran was prevented from training due to the alcohol or drug condition, and the evidence required to establish the period of such infeasibility. For instance, during the period when training was most likely impossible, the veteran would not necessarily have been in contact with any health-care professional or self-help group. In such case, there would be no evidence, other than the veteran's own statement, to establish that training was not possible, due to alcoholism or drug abuse, for long periods of time. (Some requests for extension have claimed the entire 10-year delimiting period.) There simply would be no method of confirming this allegation. Thus, it would appear that the proposed amendment, if enacted, would leave the VA to adjudicate delimiting date extensions on the most tenuous evidence, perhaps only a veteran's self-serving statement. This could open the door to widespread abuse or, alternatively, could lead to denials for lack of satisfactory evidence to support the veterans' claims. Either result would be self-defeating and disserve the Government's interests and image.

Another problem is that of determining whether the veteran is able to enter training and is, in fact, "recovered." There is a large body of medical opinion which holds that recovery from alcoholism or drug abuse is not actually possible; that it is only possible to control these conditions. Requiring that the veteran be recovered before the extension may be granted appears to be a requirement that can be neither defined nor verified.

A requirement that treatment must have been received from a person licensed to provide such treatment also appears to be undefinable and unverifiable. What constitutes the requisite treatment? There are no established licensing procedures, and types of programs vary considerably. There may be self-help, family therapy, religious counseling, medical treatment, medication maintenance, or all or any combinations of these. The Administrator would be unable to define by regulation which programs or therapists would qualify under the proposed legislation since no generally recognized and accepted criteria exist in this area. (Moreover, even if it could be determined that programs such as Alcoholics Anonymous, for example, would qualify, such programs do not keep attendance records and will not verify whether a particular veteran has, in fact, participated in the program, much less whether he has recovered.)

It must be noted, too, that the length of treatment may vary considerably, depending upon the nature of the program, as well as the provider. Within the VA's alcohol treatment programs, for instance, inpatient treatment varies in length ranging from intensive medical care of 3 days to 4 weeks, to structured inpatient care up to 12 weeks at some locations.

The recommended hospitalization for purposes of detoxification from acute alcoholism does not exceed 7 days. Additionally, inpatient care for specialized medical and psychiatric evaluation, for hospital-based treatment for the addiction, for dental, nutritional, or other urgent medical problems, and for rehabilitation, generally does not exceed 30 days in uncomplicated cases. The balance of care is provided on an outpatient basis for as long as necessary to attain the rehabilitation of the alcoholic veteran.

Clearly, the relatively short periods of acute or structured inpatient treatment would cause slight disruption to educational pursuit, raising a question as to the value of granting an extension for only such periods. On the other hand, the long periods of "treatment" under maintenance-type programs, which largely employ a self-government modality, raise questions of proof for purposes of determining entitlement to an extension of a delimiting date, and lend themselves to submission of fraudulent claims. Moreover, the latter could result in having to grant overly generous periods of extension not contempleted by the Congress as necessary to accomplish the statutory objective.

In view of the above, it is extremely dubious that the VA could adequately define eligibility requirements or draft regulations to implement a statute granting extensions of delimiting dates based on alcohol or drug abuse conditions.

At the very least, a legislative liberalization affecting determinations involving alcoholism and drug abuse conditions in connection with education and vocational rehabilitation programs would set a precedent. Such a precedent would inevitably lead to pressure to consider these conditions compensable under other benefits programs (e.g., compensation and pension). This could produce the undesirable consequences for such programs previously noted.

RCS 22-19, Extended Delimiting Dates, M22-2, Part II, Chapter 4

ANALYSIS WORKSHEET

DATE FY 1983

STATION NAME	STATION NUMBER	Chapter 34 Approved	Chapter 34 Denied	Chapter 34 TOTAL	Chapter 35 Approved	Chapter 35 Denied	Chapter 35 TOTAL
EASTERN REGION							
ATLANTA	16	4	13	17	0	0	0
BALTIMORE	13	9	1	10	0	0	0
BOSTON	01	0	1	1	1	1	2
BUFFALO	07	10	3	13	0	0	0
COLUMBIA	19	6	16	22	0	0	0
HARTFORD	08	11	3	14	0	0	0
HUNTINGTON	15	5	32	37	0	6	6
MANCHESTER	73	1	1	2	0	0	0
NEWARK	09	2	11	13	0	0	0
NEW YORK	06	2	19	21	0	1	1
PHILADELPHIA	10	18	27	45	0	0	0
PITTSBURGH	11	3	1	4	0	0	0
PROVIDENCE	04	3	0	3	0	0	0
ROANOKE	14	10	7	17	0	0	0
SAN JUAN	55	0	3	3	0	1	1
ST. PETERSBURG	17	39	43	82	2	0	2
TOGUS	02	5	3	8	0	0	0
WASHINGTON	72	8	138	146	0	4	4
WHITE RIVER JCT.	05	0	2	2	0	0	0
WILMINGTON	60	1	2	3	0	0	0
WINSTON-SALEM	18	15	5	20	2	0	2
	TOTAL	152	331	483	5	13	18
CENTRAL REGION							
CHICAGO	28	73	10	13	0	1	1
CLEVELAND	25	97	145	242	0	0	0
DES MOINES	33	0	3	3	0	0	0
DETROIT	29	12	2	14	0	0	0
FARGO	37	1	7	8	0	1	1
INDIANAPOLIS	26	1	2	3	0	0	0
JACKSON	23	4	3	7	0	0	0
LINCOLN	34	0	0	0	0	0	0
LITTLE ROCK	50	4	2	6	0	0	0
LOUISVILLE	27	6	7	13	1	0	1
MILWAUKEE	30	2	0	2	0	0	0
MONTGOMERY	22	46	20	66	1	1	2
MUSKOGEE	51	13	24	37	1	3	4
NASHVILLE	20	9	9	18	0	0	0
NEW ORLEANS	21	2	19	21	0	0	0
SIOUX FALLS	38	3	5	8	0	0	0
ST. LOUIS	31	3	11	14	0	0	0
ST. LOUIS-RPC	76						
ST. PAUL	35	27	65	92	0	0	0
WICHITA	52	9	13	22	0	0	0
	TOTAL	242	347	589	3	6	9
WESTERN REGION							
ALBUQUERQUE	40	-	-	-	-	-	-
ANCHORAGE	63	1	7	8	0	0	0
BOISE	47	5	3	8	0	0	0
CHEYENNE	42	4	0	4	0	0	0
DENVER	39	3	6	9	0	0	0
FT. HARRISON	36	1	10	11	0	0	0
HONOLULU	59	5	8	13	0	0	0
HOUSTON	62	5	4	9	0	0	0
LOS ANGELES	44	20	141	161	0	0	0
MANILA	58	1	6	7	0	1	1
PHOENIX	45	7	23	30	1	0	1
PORTLAND	48	15	21	36	0	0	0
RENO	54	0	3	3	0	0	0
SALT LAKE CITY	41	1	5	6	0	0	0
SAN DIEGO	77	9	22	31	0	2	2
SAN FRANCISCO	43	146	37	183	0	0	0
SEATTLE	46	13	9	22	0	1	1
WACO	49	4	5	9	1	0	1
	TOTAL	240	310	550	2	4	6
	GRAND TOTAL	634	988	1,662	10	23	33

VA FORM JAN 1980 **20-8587**

EXISTING STOCKS OF VA FORM 20-8587, SEP 1977, WILL BE USED.

Chairman SIMPSON. Now, we have a second panel, Dr. Ewald W. Busse, chairman, Geriatrics and Gerontology Advisory Committee; and Dr. Terrie Wetle, Harvard University Medical School.

We will have your testimony as soon as the room clears a bit. Thank you. Dr. Busse, you may proceed and then we will have Dr. Wetle. It is nice to have you with us.

TESTIMONY OF A PANEL CONSISTING OF EWALD W. BUSSE, M.D., DEAN EMERITUS, DUKE UNIVERSITY MEDICAL CENTER, DURHAM, NC, AND CHAIRMAN OF THE GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE TO THE VETERANS' ADMINISTRATION; AND TERRIE WETLE, PH.D., ASSISTANT PROFESSOR, DIVISION OF HEALTH POLICY RESEARCH AND EDUCATION, HARVARD UNIVERSITY MEDICAL SCHOOL, CAMBRIDGE, MA

Dr. BUSSE. Thank you, Mr. Chairman. I am E.W. Busse. I am the dean emeritus of Duke University Medical Center. In addition I happen to be the Chair to the Veterans' Administration Geriatrics and Gerontology Advisory Committee.

My remarks today are as an individual and do not reflect any opinion of the VA Advisory Committee on Geriatrics and Gerontology. I will limit my remarks only to that provision in S. 2514 that is concerned with referrals and arrangements of our community services.

I am quite aware that the Veterans' Administration has made a determined effort to try to meet this challenge and, as indicated by Mr. Fulton earlier this morning, I am aware that the VA has utilized their social services in various facilities to try to develop and extend their referrals and their arrangements with their community services.

I am also aware that each medical district has designated a senior professional responsible for coordination and exploring further use of community services, not only for the disabled veteran but also for the elderly veteran. It is my opinion that that section of S. 2514 gives real credibility to established VA efforts and from my viewpoint, the section has merit simply because at times it is important to have certain activities strengthened by recognition of their importance.

The adequate coordination of health and human service is a serious problem, not only within the Veterans' Administration but for the entire health-care system, particularly in what is called long-term care which usually involves elderly people. I believe that the Veterans' Administration can make numerous contributions to improving the well-being of our elderly system as well as other disabled people and for this reason, I very strongly urge this effort be supported and expanded.

I believe that soon studies will have to be put in place to determine and evaluate the various systems that are trying to be developed to do this particular effort. And I believe that it can be done.

This concludes my statement. I again want to salute you in your efforts and your determination to make this come about.

Chairman SIMPSON. Thank you, sir.

[The prepared statement of Ewald W. Busse, M.D., dean emeritus, Duke University Medical Center, Durham, NC, and chairman of the Geriatrics and Gerontology Advisory Committee to the Veterans' Administration, follows:]

PREPARED STATEMENT OF EWALD W. BUSSE, M.D., DEAN EMERITUS, DUKE UNIVERSITY MEDICAL CENTER, DURHAM, NC, AND CHAIRMAN OF THE GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE TO THE VETERANS' ADMINISTRATION

My remarks are targeted on the proposed section "Referrals and Arrangements for Community Services." This is a portion of the bill "Veterans Administration Health Care Amendments of 1984." This section addresses the serious problem of coordinating the various treatment and support programs that are often necessary to take care of the veteran with serious service-connected disability as well as the elderly veteran. A Veterans Administration health care facility cannot provide all the range of services that are often needed by these veterans. These outside services should be obtained without expenses to the Veterans Administration. To accomplish this, the amendment states that the administrator "shall designate one office in each Veterans Administration health care facility and in the Central Office to coordinate and make arrangements for the provisions of referral services." The objectives and the mechanism are meritorious. The Veterans Administration has given social work and other services within the Veterans Administration the authority and responsibility to identify and provide access to such community services for veterans.

In the past two years, the Veterans Administration has taken steps to increase the initiative of community integration both at the local level and at the level of the Central Office. Of particular importance is the Veterans Administration District Initiated Program Planning. These district plans are directly related to the coordination and utilization of community resources. Furthermore, each medical district has assigned a senior level professional as a community service coordinator for the district. Although this is sound planning, the execution of the program is difficult. Each veteran has distinct personal habits and values and differs as to family support, socioeconomic status, work skills and interests, living arrangements, and the extent of the disability. Consequently assisting a veteran to utilize profitably available resources is always a time-consuming and complex effort. It is my opinion that a small amount of additional money is needed by the Department of Medicine and Surgery of the Veterans Administration to further promote demonstration projects concerned with the integration of community resources with the Veterans Administration health care services. Programs addressing these problems would be beneficial both to the Veterans Administration and to our entire health care system.

To find practical solutions to this coordination and maximum use of resoruces, the Veterans Administration has sponsored a major conference, and it is anticipated that the papers at this conference will serve as a base for further development of a range of options for coordinating and linking services between the Veterans Administration and the community.

This same problem will be given additional attention at a long-term care planning conference which will take place in Washington DC in September, 1984.

I would like to emphasize to the Senate Committee on Veterans Affairs that the coordination of accessing and utilizing the existing resources is a major problem particularly in the area of long term care. I am convinced that the Veterans Administration can make an enormous contribution to the citizens of the United States by expanding their efforts in this area. I believe that the Department of Medicine and Surgery should be commended for their efforts and be encouraged to vigorously expand their programs.

Chairman SIMPSON. Our next witness is Dr. Wetle. Please proceed.

Dr. WETLE. Thank you, sir. I am Terrie Wetle. I am an assistant professor at Harvard Medical School in the Division of Health Policy Research and Education. In addition to that I am the associate director of Harvard's Geriatric Education Center and I am a former director of the program in long-term care at the Department of Epidemiology and Public Health of Yale Medical School.

My testimony today is based upon the work of a collaborative project between Harvard's Division of Health Policy Research and Education and Boston's VAOPC GRECC. The goal of this project has been to explore the use of VA and community-based resources to better serve the elderly. In addition to 10 background papers, that I have here but am not going to read to you today, the major product of our project is a set of options for integration of VA and community-based resources.

The process has been multidisciplinary, soliciting both VA and non-VA perspectives and has included a conference which brought together representatives of the various Federal agencies serving the elderly, staff from relevant congressional committees, local service providers and planners, and academicians involved in gerontology and health policy.

Although the project is not yet completed and the options are currently under review by the VA's Central Office, I would like to share with you a few of the specific findings and suggestions for enhanced linkages between the VA and other providers of care to elders in the community.

Our work is based on several observations. The Veterans' Administration is certainly the Nation's largest single coordinated health-care system. It is a major provider of geriatric institutional-based care, but has only begun to emphasize community-based services. It is also recognized that elderly veterans are quite likely to have multiple entitlements and eligibilities, including VA benefits, medicare, medicaid, Social Security, and services under title III of the Older Americans Act, and others. To ensure the availability of the broad array of services required by the elderly I think it is imperative that the VA develop and improve linkages with community-based providers.

The options that we suggest take into account the special health and illness behaviors of elders, as well as the existing organization of VA and non-VA services, the importance of both medical and social services in caring for elders and the barriers to coordination and collaboration among individual services and the two-service systems.

The options that we offer address the following objectives: To increase the availability of community resources for veterans; to support family care which maintains elderly veterans in their homes and, therefore, saves the expense of institutional-based services; to expand noninstitutional services; and to expand and develop care management systems.

We believe that the first step is the increased coordination of planning efforts at the local community level and this includes increased VA participation in the local health service agencies and State health coordinating councils. This would involve an expansion of the MEDIPP process to include more emphasis on long-term care.

We also believe implementation of this option requires coodination at the Federal level with agreements between, the Veterans' Administration, the Administration on Aging, and other relevant Federal agencies.

We think there are three options available to implement this sort of linkage. The first model is exchange of inkind services and expertise, recognizing that in many locations, both the VA and the community, provide services or have expertise which is in short supply in other aspects of the community sector.

We believe the VAMC hospital administrators should be given responsibility for negotiating interagency agreements and that there should be incentives available to VAMC's for taking part in them, including the recognition of such sharing arrangements in performance appraisals and changes in the formula for allocating budgets to take into account inhome and outpatient services.

A second model for the VA and the community is to develop joint programs and coordinate existing programs. This, for example, could include a recognition by the VA and State medicaid agencies of their mutual interest in both the placement of veterans in community services as well as in nursing homes and it would include an involvement of VA in coordination with the ongoing national long-term care channeling projects.

Finally, we believe that the VAMC's should have an opportunity and the resources available on a flexible basis to pool their funding with the community-based agencies to develop new services which either agency may not have the resources or the impetus to develop on its own.

We have a precedent for this in the authorization of construction funds for State nursing home programs, which appears to be both efficacious and efficient for the VA. We recommend that such programs serve both older veterans and nonveterans, increasing the likelihood of enthusiastic community participation on both parts.

I will not go into a description of our suggestions for supportive services for family providers. That is provided in some detail in my written testimony.

Chairman SIMPSON. Thank you very much, doctor.

[The prepared statement of Terrie Wetle, Ph.D., assistant professor, Division of Health Policy Research and Education, Harvard University Medical School, Cambridge, MA, follows:]

PREPARED STATEMENT OF TERRIE WETLE, PH.D., ASSISTANT PROFESSOR, DIVISION OF HEALTH POLICY RESEARCH AND EDUCATION, HARVARD UNIVERSITY MEDICAL SCHOOL, CAMBRIDGE, MA

My testimony today is based upon the work of a collaborative project between Harvard's Division of Health Policy Research and Education and Boston's VAOPC GRECC The goal of this project has been to explore the use of VA and community based resources to better serve the elderly. In addition to ten background papers, the major product of this project has been a set of options for integration of VA and community resources. The process has been multidisciplinary, soliciting VA and non-VA perspectives and included a conference which brought together representatives of the various federal agencies serving the elderly, staff from relevant Congressional committees, local service providers and planners, and academicians involved in gerontology and health policy.

Although the project is not yet completed and the options are currently under review by the Veterans Administration, I would like to briefly share with you our preliminary findings and suggestions for enhanced linkages between the VA and other providers of care to elders in the community. The comments I offer are not intended to represent the official views of the Veterans Administration, but rather those of the faculty and staff of the Harvard Project on VA/community Resources and the Older Veteran.

Our work has been based on several initial observations. The Veterans Administration is the nation's largest single coordinated health care system. Although the VA is a major provider of insititutionally based geriatric care, there has been far less emphasis on community based services. The VA faces a clear geriatric imperative not only because of increases in absolute numbers of elder veterans, but because the mix of services by the elderly differs from that of other age groups. It is also recognized that the majority of veterans have multiple elligibilities and entitlements including VA benefits, Medicare, Medicaid, Social Security, and services provided under the Older Americans Act. To ensure the availability of the broad array of services required by elder veterans the VA must develop and improve linkages with community based providers.

The options suggested here take into account the special health and illness behaviors of elders, the existing organization of VA and non-VA services, the importance of both medical and social services in caring for elders and the barriers to coordination and collaboration among individual services and the two service systems. The options address the following objectives,

- o to increase the availability of community resources to veterans
- o to support family care which maintains veterans at home
- o to expand non-institutional services, and
- o to expand and develop care management.

The options also address the themes of education, research and the targeting of services.

VA/COMMUNITY RESOURCES
AND THE OLDER VETERAN

4018h

VA/COMMUNITY OPTIONS FOR SERVING THE ELDER VETERAN

OPTION 1 Increase the Availability of Community Resources by

- a. greater coordination of planning efforts
- b. increased sharing of VA/Community resources

OPTION 2 Support Family Care to Aid in Maintaining Veterans at Home by

- a. supportive services to family care providers
- b. direct services to supplement family care

OPTION 3 Expand Non-institutional Services by

- a. expanding Housebound Benefits for non-service connected to allow for purchase of non-VA services
- b. expanding current Disability Pension program to allow for purchase of non-VA services
- c. expanding definition of medical services to include home-health and home-help services

OPTION 4 Expand and Develop Care Management including

- a. comprehensive functional assessment
- b. monitoring high risk elders

THEMATIC RECOMMENDATIONS

1. Education
    - a. VA Geriatric Education Centers
    - b. Faculty development
    - c. Health Education/Health Promotion modules
2. Research
    - a. Evaluation of health delivery programs as primary HSR&D activity.
    - b. Removing barriers for HSR&D demonstrations of joint VA/Community projects.
    - c. Prospective study of functional assessment and surveillance of high risk elders.
3. Targeting
    - a. Programs targeted to veterans at greatest risk of high utilization and long term institutionalization
    - b. Simplification of eligibility criteria

OPTION 1 - INCREASE THE AVAILABILITY OF COMMUNITY RESOURCES BY:

A. GREATER COORDINATION OF PLANNING EFFORTS

Increased coordination of planning efforts at the local level will require an expansion of VA activities in community planning. This would include active VA participation in the work of local Health Systems Agencies, State Health coordinating Councils, Area Agencies on Aging, State Medicaid Departments and State Units on Aging. Familiarity with existing community resources which can supplement or replace the need for VA services will enable the VA to meet the needs of elder veterans and will alert the VA to unmet community needs for which VA resources are particularly well suited. This activity can be viewed as a natural growth and expansion of the MEDIPP.

To implement this option, VA Central Office should emphasize the importance of including planning for long term care services in MEDIPP activities. This expansion of the MEDIPP will require relatively few additional resources. To insure that each VAMC is an active participant in community planning, staff at each VAMC should be identified for this responsibility. Traditionally, this has been viewed as a social services activity. And while it is recognized that much of the necessary information and many of the required skills are available through social work, we recommend that the importance of this process requires direct participation of administrative staff and representatives of the various VAMC departments. Special units should be developed at each VAMC with responsibility for this and other community interactions.

Implementation of this option also requires coordination at the national level. Agreements to coordinate planning activities should be negotiated with the Administration on Aging, Health Care Financing Administration and other relevant federal agencies, similar to the recent agreement regarding Information and Referral Actitivies.

B. INCREASED SHARING OF VA/COMMUNITY RESOURCES

Three overlapping models for increased sharing of VA/Community Resources are offered. The first model suggests an exchange of in-kind services and expertize, recognizing that, in many locations, both the community and the VA provide services or have expertize which is unavailable or in short supply in the other sector. The relative distribution of scarce resources and expertize differ from one location to the next, but the general pattern would indicate that the community offers day care, home health and home help, and other forms of social support as well as nursing home beds, foster care and congregate housing. The VA, on the otherhand is more likely to possess expertize in rehabilitation, geriatrics, and treatment of certain special diseases such as stroke and spinal cord injury as well as services such as domiciliary care, extended hospital care, and hospital-based home care. Hosptial administrators should be given responsibility for negotiating interagency agreements between community providers and the VA. Incentives to VAMCs to participate in such sharing arrangements should include flexibility in program guidelines, inclusion of sharing arrangments in the performance appraisal process, and changes in the formula for allocatng budgets to take into account in-home and outpatient services.

A second model for coordinating VA/community activities is the joint development of new programs and the coordination of existing programs. This concept, as successfully implemented in the CHEP, requires the development of consortia of service providers to plan and develop new programs. A notable example of such an effort would be a cooperative effort between the VA and State Medicaid agencies around providing long term services. Under such an arrangement, these two entities would coordinate the provision of home-based services and the placement of elders in nursing homes. In another example, the VA at the local and national level, could become involved in projects similar to the ongoing National Long Term Care Channeling Project.

A third model for coordinating VA/Community activites to better serve the older veteran is to pool resources to develop new services. Under such an arrangement, each agency contributes resources in order to develop a new program, under circumstances in which no single agency is able or willing to provide the program alone. It is likely that extensive pooling of resources would require changes in regulation and legislation. Precedent does exist however, in the authorization of construction funds for state nursing homes for veterans, a peogram which is both efficacious and efficient for the VA. We recommend that such programs serve both older veterans and non-veterns, increasing the likelihood of enthusiastic community participation.

OPTION 2 - SUPPORT FAMILY CARE TO AID IN MAINTAINING VETERANS AT HOME

A. PROVIDE SUPPORTIVE SERVICES TO FAMILY CARE PROVIDERS

An important factor in maintaining the elder veteran at home is the availabilty and willingess of family members to provide care. The VA can expand two sets of activities which will enhance the willingness and capacity of families to provide home care. The first set of activities supports family care. Services to be provided include; technical assistance in learning new skills, counseling, family mental health servies, personal supports and a variety of respite or emergency services. For the most part, these services are provided directly to the care provider. Services of this sort recognize the substantial efforts made by family caregivers and the potential stresses of caretaking. One option is to develop VA programs which use VA staff and volunteers to provide counseling and skills development. These programs would most likely emanate from VA medical centers and outpatient clinics but would be most effective if offered in the client's home and in geographic locations close to home. Use of telephone contacts certainly would expand the impact of a VA support program and reduce fiscal and personal costs (e.g., travel, inconvenience) and is likely to be quite effective if supplemented by home or clinic visits. Such services would represent an extension of the life-line concept already in use with some veterans and of the contact person approach offered to patients and family members at some VA medical facilities.

Another approach for the VA in developing supports for caretakers is to develop sharing arrangements with community agencies. The exact "format" (e.g., contracts, pooling of resources, "trading of services") of such sharing arrangements is discussed in other options in this series. It should be recognized, however, that programs to support family caregivers are not common in community service systems across the country and, in fact, will be a novel idea in many communities. This provides the VA with a good opportunity for early involvement in the planning and implementation of such programs, serving as a full partner, and perhaps innovator, in the community development process. Further, a project such as this lends itself well to sharing arrangements in which a VA medical center may provide family support services to a combination of veterans and non-veterans in its immediate geographic area in exchange for similar services provided to veterans by community agencies in areas which are not geographically convenient to the VA facility.

B. SERVICES WHICH SUPPLEMENT FAMILY CARE

The VA has before it a rich array of options for supplementing family care. Strictly speaking, any service which eases the burden of caregivers falls into this category, including: home health care, chore services, day hospitals, friendly visitors, and even temporary institutional care. For supports to care providers to be most cost-effective, they should supplement, not supplant, family services.

In addition to the usual array of home health and social services that may be used to supplement and enhance family care, respite care services are particularly important in family care situations. The VA has a number of options before it for providing respite care, some requiring legislative changes. VA medical centers already provide "unintentional" respite care for families in crisis who bring in an elder for admission to the acute hospital for more or less "real" medical problems. "Deliberate" respite care allows for the provision of needed services with appropriate levels of staffing and intervention. The VA already offers some deliberate respite care and has the potential to offer such care in a variety of its institutional and residential settings, including acute care, extended care, nursing homes, and perhaps even domiciliary care.

Day hospitals and adult day care are other forms of support which supplement family caretaking. Again, the VA may choose to initiate day care and day hospital programs at VA medical centers or may choose to enter into sharing arrangements with community agencies in order to access elder veterans to these services. If sharing arrangements are selected, coordination with the AoA at the national level and with the Department of Veterans Benefits for implementation purposes is likely to be beneficial.

OPTION 3 - EXPAND NON-INSTITUTIONAL SERVICES

A. EXPAND HOUSEBOUND BENEFITS PROGRAM

It is recommended that geriatric care coordinators be allowed to petition local veterans benefit counselors for Housebound Benefit allotments to be used to support a care plan developed by the care coordinator and the elder patient.

B. EXPAND THE CURRENT DISABILITY PENSION PROGRAM

It is recommended that geriatric care coordinators be allowed to petition the pension board for aid and attendance allotments for high risk elders. These allotments could then be used to support a care plan developed jointly by the elder patient and care coordinator.

C. EXPAND THE DEFINITION OF VA HEALTH SERVICES TO INCLUDE HOME HELP

Because of the special problems associated with chronic diseases common in old age, the provision of home-based services is required to prevent untimely institutionalization. The current VA definition of health care should be expanded to allow for providing home-based services such as home health aids and home helps.

OPTION 4 - EXPAND AND DEVELOP CARE MANAGEMENT FOR HIGH RISK ELDER VETERANS

A. IDENTIFY VAMC UNITS RESPONSIBLE FOR CARE MANAGEMENT

It is recommended that the VA further expand care management by identifying a unit within each VAMC responsible for this activity. Care managment should include careful functional assessment in addition to the usual identification of needs and resources. This care management function should include the active participaton of the disciplines of social work, nursing, medicine and therapies as necessary. Care managment should be coordinated with community-based services to ensure that the full array of necessary services are available.

B. DEMONSTRATION OF CARE MANAGEMENT OF HIGH RISK ELDERS

It is further recommended that the VA launch a major demonstration of care management through assessment and monitoring high risk elder veterans. Patients would enter this program for screening through one of three routes; referred by physician (any patient over 65), referred by self or any provider (any patient over 75) or any elder patient for whom nursing home placement is a consideration. An initial screen would identify the target group, those at high risk of heavy utilization of service, and would carefully assess them at regular intervals, bringing them in for appropriate interventions as needed.

THEMATIC ISSUES WHICH BRIDGE OPTIONS

EDUCATION

The goal of program development in geriatric education for the Veterans Administration (VA) is to assist each VA Medical Center (VAMC) and Outpatient Clinic (OPC) to adequately meet the health care needs of the elder veteran population it serves. These needs shall be met by providing an educational component within the VA which teaches the knowledge base, skills and attitudes required for health professionals to be successful in caring for elderly individuals.

ASSUMPTIONS

1. There is a variable but generally substantial need for education of health professionals in the American system of care, both in and out of the VA, concerning care of the elderly.

2. There is a well identified body of knowledge, required for successful geriatric care, which can be taught to health care providers.

3. The VA shall take a leadership role in educating health professionals to care for the elderly.

4. There is an urgent need for VA/community interaction in geriatrics, and the educational sphere presents an excellent opportunity for such cooperation.

5. Funds will be available for support of needed activities and positions to accomplish the above.

A. DEVELOPMENT OF VA GERIATRIC EDUCATIONAL COMPETENCE

Foci of geriatric educational competence within the Veterans Administration should be created at certain VAMCs which are already endowed with geriatric and academic resources, such as:

a. faculty competent in geriatrics
b. teaching nursing home or fertile nursing home environment
c. RMEC
d. CHEP
e. medical school affiliation

These activities should reside within the educational program of existing GRECCs and be incorporated into each new GRECC established henceforth, eventually serving all 28 VA regions nationally. These foci shall be designated VA Geriatric Education Centers (VA GECs).

The Health Resources and Services Administration initiative, creating four regional Geriatric Education Centers (GECs) nationally, should provide some useful models for the Veterans Administration in its deliberations concerning geriatric education. These GECs have been created to enrich educational opportunity in geriatrics for health professionals through faculty training and technical assistance. The regional GECs provide on-site training in geriatrics for faculty from health professional schools who will then return to their own institutions to augment or establish geriatric educational programs. In addition, each Center serves as a clearing house for selected educational materials and curricula as well as providing consultation and technical assistance in geriatric program development.

o VAMCs with GRECCs should develop the VA GEC as an expansion of current educational activity within the GRECC. Additionally, VAMCs and GRECCs in regions with a CAGP or REMC should collaborate with them in geriatric educaional development.

o For VAMCs with fewer geriatric resources, health care providers can be sent for short term intensive training in geriatrics at VA GECs. The VA should consider developing formal certification in geriatrics for individuals completing such training experiences.

o A very small number (?1) of VA GECs will, in collaboration with non-VA resources (such as a site with an HRSA GEC), take responsibility for developing geriatric educational exports. These products will be used at remote VAMCs to enhance geriatric care capability among providers, and will also be available to the community.

B. FACULTY DEVELOPMENT

A major focus of educational programs in geriatrics within the VA should be increased capacity to produce faculty as well as care providers in geriatrics through enlargement and modification of the geriatric medicine and dental fellowship programs, especially at GRECCs; and by development of fellowship programs in additional disciplines, such as nursing and allied health.

All training in geriatrics should emphasize interdisciplinary team function as well as more traditional discipline-specific teaching. Since physicians are team leaders and have generally lagged behind other disciplines in interdisciplinary team function and education, special effort should be made to capture interest and attention of physicians. The ITTG program should be expanded to accomplish this end.

C. HEALTH EDUCATION/HEALTH PROMOTION FOR THE OLDER VETERAN

It is recommended that educational activities also focus on the older veteran and family members. Health education/promotion materials and modules should be developed at VA GECs to educate elders to the development of appropriate illness behaviors. These modules should cover: facts about disease in old age, with special emphasis on developing appropriate attitudes and changing ageist beliefs: early detection of disease, with special emphasis on learing to recognize symptoms of diseases particularly those non-specific symptoms which characterize the different presentation of disease among the old; self-care skills; and information about effective negotiation of the health care system.

A veriety of formats should be used for health education/promotion activities. For many topics, group approaches using volunteers with similar situtations are quite effective. Inclusion of family members will serve to reinforce newly developing health behaviors in the older veteran.

D. VA-COMMUNITY INTERACTION

VA Geriatric Education Centers should provide educational services for community as well as VA personnel. Priority shall be given to training VA providers, but non-VA personnel will also be eligible. Community strength in geriatric education related to health care will be used to develop new or augment existing capabilities within the VA.

- VAMCs will consult and collaborate with community sources of expertise in geriatric education to assist the VAMC in developing VA geriatric educational programs. Such community resources include geriatric programs in health professional schools, clinical service sites, AHECs, AAAs, HRSA GECs, university social gerontology centers or programs, and state or regional educational programs sponsored by the American Association of Homes for the Aged and the American Health Care Association.

E. COMPREHENSIVE FUNCTIONAL ASSESSMENT

Comprehensive functional assessment should be a cornerstone of the VA curriculum in geriatric care, with a priority to develop and use a system-wide assessment instrument and common language. Geriatric Evaluation Units already in existence should lead this effort.

F. OTHER RECOMMENDATIONS

- Teaching Nursing Homes on a flexible model should be developed at affiliated VAMCs where credible faculty can be identified.
- The Assistant Chiefs of Staff for Education (ACOSEs) should convene nation-wide to discuss issues and initiatives for increased geriatric education in the VA and how their local communities should be involved.
- For geriatric education and training, the "1/6" rule should be liberalized, allowing more VA-community interaction.
- There should be legislative change enabling RMECs to teach non-VA personnel.
- The VA should develop new programs using volunteers to establish and maintain linkages of VA and community resources for the elderly. Volunteers represent a valuable and neglected resource for patient education and service coordination for the VA elderly population.

RESEARCH

If the VA were to develop an array of new initiatives to promote VA-community interaction in the care of the elderly veteran, it would provide further opportunities to conduct useful health services research which will guide future efforts. The following recommendations result from the discussions at the conference.

A. EVALUATION OF VA/COMMUNITY ACTIVITIES

As with other interventions, it would be appropriate for the VA to include an HSR & D component in all new substantive health care delivery programs in the VA-community interaction sphere. A primary HSR&D activity would be evaluation. New technologies, such as assessment instruments or patient monitoring models, introduced in the VA-community interaction initiative should be the subject of rigorous health services research including randomized controlled trials. Adequate resources to conduct such research should be included in program planning.

B. REMOVING BARRIERS TO COLLABORATIVE VA/COMMUNITY RESEARCH

The VA should move immediately toward removing substantive administrative barriers to HSR&D demonstrations and evaluations in projects conducted jointly by VA and non-VA investigators.

C. PROSPECTIVE STUDY OF FUNCTIONAL ASSESSMENT AND SURVEILLANCE

There should be a prospective study of functional assessment and surveillance of high risk older veterans in order to identify the value, if any, of such an effort in targeting community services to focus on older veterans (greater than 70 or 75 years of age) with functional impairment, acute confusion or other conditions likely to increase the risk of institutionalization. As we invision such a study, it will begin with comprehensive functional assessment, followed by an intervention consisting of monitoring and early treatment. Outcomes to be measured include functional and health status and use of VA and community health and other services.

Chairman SIMPSON. Just a couple of questions, Dr. Busse, the VA has said that agency aging plan, which is entitled "Caring for the Older Veteran—A Shared Vision for the Future," will soon be released. Have the members of the Geriatric and Gerontology Advisory Committee which you chair had an opportunity to review any drafts of that?

Dr. BUSSE. No, the committee has not had that opportunity.

Chairman SIMPSON. We would look forward to that.

Dr. BUSSE. We, the Advisory Committee, are very concerned that we have not had this opportunity. We anticipated that we would have the Aging Plan early in this year, as we wanted to address the report during our February meeting. It was not available and there is considerable concern with this delay. Consequently we cannot respond to the charge to this committee, set forth in Public Law 96-330. The committee is responsible for assessing the ability of the Veterans' Administration to deliver quality care to the elderly veteran.

Chairman SIMPSON. I cannot recall the date that was to be released, this spring, I think, sometime. I think it is very important that you have access to that and I will try to see that you have access to a draft of that or at least some information on it. Do you think that has been detrimental to your efforts?

Dr. BUSSE. Yes, it has, because some of our committee quite properly were involved in developing the draft on the care of the aging veteran and that was back last fall. They do have concern as to what has happened to their efforts.

Chairman SIMPSON. I think that Administrator Walters will visit with you about that. I have come to have great regard for him.

Just another question, the referrals and arrangements provision in S. 2514 targets service connected at 50 percent or more and elderly veterans. In your experience, are these groups the ones most in need of this coordination of services approach to care? Who else would you recommend in that area and who of the groups would benefit most by coordination efforts that we have been discussing?

Dr. BUSSE. My response would be that it is true that the more disabled the individual, the more services are required and the better cooperation and integration. However, I would also point out that in the elderly group, particularly those 85 years old and over, and they will gradually increase, so that there are many of those over 65 who do not require quite the extent of the integrated cooperative effort with the community.

Chairman SIMPSON. Just a couple of questions for Dr. Wetle. The provisions of S. 2514 dealing with the referrals and arrangements for these community services suggest a designation of a center of responsibility at the VA medical facilities to coordinate referral activities. Do you agree with that approach? Have you alternatives which may be more decentralized, such as leaving the problem with actual providers of care, such as social workers, nurses, and doctors? Do you have any response to that?

Dr. WETLE. We have given that considerable thought in both our examination of non-VA programs as well as looking at some of the barriers to coordination within the VA. My feeling is that because the disabled persons as well as the elders who would require such coordination tend to be those with multiple illnesses, they require the services of many types of providers and the problem is bigger than any one service or department. Having a recognized focus within each VAMC is important. Of course, this should involve the active participation of the department of social work, because they have special skills that are required, but representatives of other important departments is essential in my view.

Chairman SIMPSON. A moment ago, you referred to barriers to linkages between the VA and the community. What are some of those barriers?

Dr. WETLE. In my view—first, we all recognize that under the current legislative mandate the VA cannot provide the full array of care required and the issue becomes whether the extensive community service providers cooperate with the VA in providing service to veterans. Unfortunately, many community service providers look at their own shrinking budgets and increasing demands and feel that cooperation with the VA is a one-way street in terms of sharing and that they only see an even greater demand for their services without resources made available to help with the provision of that care.

That is why in the listing of options we suggested opportunities for the VA to use its special skill and expertise to offer something in return, to provide these joint projects in such a way that there is something of good in it for everybody. The one-way street issue is one kind of barrier.

I think another important barrier is the lack of incentives within the VA to enter into such agreements. It is obvious that veterans need services and the social service department does reach out to get those services, but in the performance appraisal for the VAMC each year, the major focus is on inpatient care. So inasmuch as time and efforts and resources are spent on these outpatient care activities, they really do not get counted in the same way.

These are two very important barriers.

Chairman SIMPSON. They are indeed. I thank you very much for your testimony. Thank you for coming.

[The responses of Ewald W. Busse, M.D., dean emeritus, Duke University, Durham, NC, and chairman of the Geriatrics and Gerontology Advisory Committee to the Veterans' Administration, to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, and Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follow:]

RESPONSE OF EWALD W. BUSSE, M.D., DEAN EMERITUS, DUKE UNIVERSITY, DURHAM, NC, AND CHAIRMAN OF THE GERIATRICS AND GERENTOLOGY ADVISORY COMMITTEE TO THE VETERANS' ADMINISTRATION, TO A WRITTEN QUESTION SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question. Section 2 of S. 2514 would enhance the management of VA medical treatment programs by providing for the referral of veterans to non-VA entities and improving the relationship between VA medical facilities and the communities in which they provide care to veterans. In terms of this provision in S. 2514 regarding referrals and arrangements for community services, what do the communities gain from a better cooperation with the Veterans' Administration?

Answer. My response must focus upon the advantages offered the individual patient, and in this case particularly, the veteran who will benefit from a coordinated plan of treatment, rehabilitation, and support. The Veterans' Administration cannot provide all of the services that are needed by veterans as they return to their communities. Therefore, it is essential that sharing arrangements be developed. It is my belief that the leadership within the Veterans' Administration can develop adequate plans and implement these efforts if they are given broader authority for sharing arrangements. This type of undertaking is a complex one and it would be very wise to institute, at a relatively small cost, several demonstration projects moving to a broader approach.

RESPONSE OF EWALD W. BUSSE, M.D., DEAN EMERITUS, DUKE UNIVERSITY MEDICAL CENTER, DURHAM, NC, AND CHAIRMAN OF THE GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE TO THE VETERANS' ADMINISTRATION, TO A WRITTEN QUESTION SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question. Please give me your views on the relationship of bereavement counseling to hospice care and, specifically, your views on the extent to which counseling and assistance to the family, both before and after the patient's death, must be an integral part of a hospice-care program.

Answer. It is my opinion that bereavement counseling for the family and friends is an integral part of any well planned, functioning hospice care program. Such counseling is extremely productive prior to the patient's demise, but on occasion it is necessary to work with family and friends who encounter unforeseen difficulties. Therefore, it would be wise for the Veterans' Administration to have the authority to extend counseling and assistance to the family for six months after the veteran's death.

Chairman SIMPSON. The panel consists of Dr. Leonard Saxe of the Office of Technology Assessment, accompanied by Ms. Denise Dougherty; Ms. Sandra K. Hill of the Baltimore Alcoholism Treatment Center; and Leo Ruffing, Association of Halfway House Alcoholism Programs of North America, Inc.

We do have a time constraint rushing in on us, but each of you, Dr. Saxe, Ms. Hill and Mr. Ruffing, have 5 minutes to summarize your testimony. We appreciate receiving your testimony in the order as set up in the agenda.

Thank you.

TESTIMONY OF A PANEL CONSISTING OF LEONARD SAXE, PH.D., PSYCHOLOGIST, BOSTON UNIVERSITY, ACCOMPANIED BY DENISE DOUGHERTY, OFFICE OF TECHNOLOGY ASSESSMENT; SANDRA K. HILL, R.N., C.A.C., M.B.A., DIRECTOR, SUBURBAN HOSPITALS' ALCOHOLISM TREATMENT SERVICES, BETHESDA, MD, AND PRESIDENT, BOARD OF TRUSTEES, BALTIMORE ALCOHOLISM TREATMENT CENTER, BALTIMORE, MD; AND LEO RUFFING, MEMBER OF THE BOARD OF DIRECTORS, ASSOCIATION OF HALFWAY HOUSE ALCOHOLISM PROGRAMS OF NORTH AMERICA, INC., ST. PAUL, MN, ACCOMPANIED BY DONALD ANDERSON, DIRECTOR, SERENITY HOUSE ALCOHOLISM RECOVERY PROGRAM, NEWPORT NEWS, VA

Dr. SAXE. Thank you, Mr. Chairman, we are pleased to appear this morning to discuss the implications of recent scientific research for the provision of alcoholism treatment by the VA. I am a psychologist on the faculty of Boston University and senior author of the Congressional Office of Technology Assessment's report on the "Effectiveness and Costs of Alcoholism Treatment."

With me is Denise Dougherty who was coauthor of the report and is a staff member at OTA. Our testimony today is drawn directly from the OTA report and I request that a copy of my statement be a part of the record, along with a copy of the report.

Chairman SIMPSON. Without objection, it is so ordered.

Dr. SAXE. I would like to make three sets of comments very briefly. First, about the alcoholism problem, and, second, about current research on alcoholism treatment, and, third, on some specific comments on S. 2514.

Let me turn to the problem. Alcoholism, I think, is only beginning to be understood, but one thing is very, very clear and that is that the cost of not treating alcoholism is tremendous. We estimated the overall cost to society of alcoholism in 1982 dollars could have been as high as $120 billion, amounting to at least $10,000 a year for every alcoholic. Alcohol abusers cost the VA over $121 million in 1982 in direct alcohol treatment costs.

This figure, however, dramatically underestimates the actual cost to the VA because it neglects the increased costs of treating any illness of an alcoholic. The VA estimates that between 20 and 50 percent of all patients are alcohol abusers. Because many patients' health problems are associated with alcohol abuse, the VA's alcohol-related health-care costs are substantially greater than those of its treatment programs alone. Attention to patients' problems with alcohol should save the VA a substantial amount in reduced health-care utilization over the long term.

Economic findings about alcoholism are related to the growing evidence that alcohol abuse is implicated in a wide range of problems, including cardiovascular disease, neurological disorders, and cancer. The recently published "Encyclopedic Handbook of Alcoholism" includes 19 separate chapters on the medical problems associated with alcohol abuse along with a dozen more on the social problems associated with alcohol abuse.

The central question that is particularly relevant to the VA is which of the many treatments available for alcoholism are most effective and the least costly in terms of benefits generated. Treatments for alcoholism range from the use of drugs which make it unpleasant to ingest alcohol to psychological treatments based on changing individuals' patterns of behavior. Alcoholics Anonymous, perhaps the most frequently discussed, is not really a treatment, but is designed to serve as a resource and support system for alcoholics.

Treatment can take place in general hospitals, in psychiatric hospitals as well as in specialized alcoholism treatment facilities. Inpatient treatment is usually differentiated from outpatient treatment, which can take place in physicians' offices or other health provider facilities. Some place between inpatient and outpatient are what are called intermediate care facilities, such as halfway houses.

Most research which has looked at alcoholism treatment effectiveness has determined that it is difficult to know which is the most effective treatment. Available research does, however, suggest the direction that policy and research should take.

Very briefly, it appears that any treatment for alcoholism is better than no treatment. From 45 to 63 percent of patients in the studies we reviewed showed significant improvement although few maintained abstinence for very long. This was much greater than what we would expect without treatment.

Perhaps the most controversial research and treatment issue concerns the necessity for hospitalizing alcoholics, that is, providing treatment on an inpatient basis, other than that necessary for detoxification or dealing with other medical complications versus providing treatment on an outpatient basis.

Several studies have found that inpatient treatment does not seem superior to outpatient treatment. I think an important finding, however, is that the inpatient/outpatient distinction is probably not very useful. Efforts to distinguish systematically the characteristics of studies reporting good and bad outcomes have indicated that inpatient treatment was valuable. However, it also suggests that an inpatient setting without an intensive community milieu and aggressive outpatient followup would be of limited value. The studies reporting very good outcomes were also characterized by a variety of other characteristics such as the use of Antabuse, social casework, family therapy, involvement of employers, and behavioral therapy.

Let me skip to the completion and I will very briefly summarize the thrust of what we are trying to achieve.

Chairman SIMPSON. Thank you.

Dr. SAXE. The thrust of S. 2514 generally is consistent with our assessment of research findings. The bill establishes outpatient options and includes development and implementation of treatment plans requiring long-term followup. These elements appear to be cost effective treatment solutions. Their application should assist in providing treatment to those in need of services and reducing the overall burden of health-care treatment and costs within the VA.

Intermediate care facilities, such as halfway houses, may be particularly useful for some populations. After detoxification, there may be no need for certain patients to be in medically oriented inpatient facilities. The halfway house may be a cost efficient option.

Perhaps the most important feature of the legislation is the requirement that individual treatment plans are developed, implemented and monitored. Recent research and literature on alcoholism treatment has stressed the need to tailor treatment to individual needs. Treatment planning is, thus, critical and should result in different treatment strategies.

The provision of the bill that there be 1-year followup is also consistent with our scientific understanding. Let me say that most treatment currently is what I call frontloaded. It occurs upon identification of the disorder but does not follow through. Follow through is essential; particularly in the VA it is difficult.

Let me stop my comments there.

Chairman SIMPSON. Thank you very much. As in the testimony you just gave, some treatment is better than none and some testimony is better than none. I hate to do it that way. I wish we could do it differently. I appreciate it very much.

[The prepared statement of Leonard Saxe, Ph.D., psychologist, Boston University, follows:]

PREPARED STATEMENT OF LEONARD SAXE, PH.D., PSYCHOLOGIST, BOSTON UNIVERSITY, BOSTON, MA

Mr. Chairman and Members of the Committee:

We are pleased to appear this morning to discuss the implications of recent scientific research for the provision of alcoholism treatment by the Veterans Administration. I am Dr. Leonard Saxe, a psychologist on the faculty of Boston University and senior author of the Congressional Office of Technology Assessment's (OTA) case study, The Effectiveness and Costs of Alcoholism Treatment. With me is Denise Dougherty who was co-author of the alcoholism case study and is a staff member at OTA. Our testimony is drawn directly from the OTA assessment of alcoholism treatment. On the basis of the assessment, we will describe the nature of the alcoholism problem, research findings about treatment effectiveness, and the implications of OTA's findings with respect to S.2514, the "Veterans' Administration Health Care Amendments of 1984."

Alcoholism Problem

OTA's investigation of alcoholism treatment was requested by the Senate Finance Committee. In responding to this request, we conducted an exhaustive review of existing theoretical and empirical research on alcoholism treatment. In addition, we met and talked with experts in medicine, psychology, social work and a number of other disciplines concerned with alcoholism treatment. The resulting OTA paper was carefully reviewed by over 50 clinicians and researchers who represented a broad spectrum of the alcoholism field.

One of our principal conclusions can be stated simply: The cost of not treating alcoholism is tremendous. Consequently, treatment, even if limited in impact, may nevertheless be cost-effective. Based on data collected and analyzed by economists, we estimated that the overall cost to society of alcoholism, in 1982, could have been as high as $120 billion -- amounting to at least $10,000 a year for every alcoholic. These costs include lost productivity as a major component, but also include subtantial health system costs. Alcohol abusers cost the Veterans Administration over $121 million in 1982 in direct alcohol treatment costs. This number, however, drastically underestimates the cost of alcoholism to the Veterans Administration because it neglects the increased costs of treating any illness of an alcoholic. For our nation's population as a whole, it is estimated that 15% of total health care costs are related to alcohol abuse. In the Veterans Administration it is estimated that between 20 and 50% of all incoming patients are alcohol abusers. Because many of these patients' health problems are undoubtedly associated with alcohol abuse, the VA's alcohol-related health care costs are substantially greater than those of its alcohol treatment programs alone, and attention to patients' problems with alcohol should save the Veterans' Administration substantial amounts in reduced health care utilization over the long term.

Our findings about the economics of alcoholism are related to the growing evidence that alcohol abuse is implicated in a number of medical problems. Cirrhosis of the liver has, traditionally, been the focus of analyses of morbidity and mortality due to alcohol abuse. It is now clear, however, that many other problems, including cardiovascular disease, neurological disorders and cancer are also related to alcoholism. In addition, a substantial number of mental health disorders and social problems, ranging from marital conflict and child abuse to criminal behavior, have been associated with excessive drinking. For the general population, most dramatic is the fact that alcohol use is implicated in perhaps 55% of all automobile fatalities, killing over 30,000 individuals per year. The recently published Encyclopedic Handbook of Alcoholism includes 19 separate chapters on the medical problems associated with alcohol abuse along with a dozen more on the psychological and social problems of alcohol abuse.

The multiple and extensive effects of alcoholism reflect the complexity of the disorder. Not surprisingly, a number of schools of thought exist about the progression and treatment of alcholism. The strictly medical perspective focuses on biological, chemical, and genetic factors. From the medical point of view, alcoholism is a disease caused by physiological malfunctioning. However, an increasingly significant perspective based on the experience of treating alcoholics is based on psychological principles. Psychologically oriented practitioners and researchers tend to view alcoholism as arising from motivational and emotional dysfunctions. An additional point of view has been referred to as the socio-cultural perspective. Alcohol abuse is viewed as the product of social and cultural factors -- a person's environment.

Although it may appear that the medical, psychological and socio-cultural perspectives represent very different approaches to alcoholism, these views are not necessarily contradictory. It is likely that each explains an aspect of the problem. Alcoholism is probably best described as an interaction of physiological, psychological, and social conditions. As such, alcoholism is extremely difficult to treat, particularly if treatment is limited in time or modality. Effective treatment requires multiple approaches.

Research Evidence

A central question which OTA's alcoholism report attempted to answer was which of the many treatments available are the most effective and least costly for the benefits generated. This analysis is particularly relevant for the Veterans Administration. Treatments for alcoholism range from the use of drugs which make it unpleasant to ingest alcohol to psychological treatments based on changing individuals' patterns of behavior. Alcoholics Anonymous (AA), perhaps the most frequently discussed approach to alcoholism, is not really a treatment, but is designed to serve as a resource and support system for alcoholics. The effects of AA have not been systematically studied, but many treatment programs have an AA component and encourage AA membership.

Frequently, treatments are distinguished by their setting -- particularly, inpatient or outpatient -- although such a distinction does not really acknowledge that almost all treatment modalities can be employed in any setting. In addition, gross distinctions among treatment settings do not acknowledge that there are important differences between types of inpatient settings. Treatment can take place in general hospitals (as is typically the case in the VA), in psychiatric hospitals, as well as in specialized alcoholism treamtent facilities. Medically oriented outpatient treatment can take place in physicians' or other health providers' offices, in community clinics, and day hospitals. Outpatients can be seen daily (e.g., in a day hospital facility) or several times a week in individual or group therapy and in AA groups. Another type of care is called intermediate care because it is somewhere between in- and outpatient but is non-medically based. Intermediate care facilities are usually community based peer oriented facilities, including halfway houses, which provide food, shelter and a supportive environment as well as treatment while patients prepare to return to their communities and jobs if they have them.

One complication concerning alcoholism treatment has to do with distinguishing detoxification from treatment, per se. An individual with a serious alcohol problem may need to be detoxified before treatment can begin. Detoxification is typically conducted on an inpatient basis, but increasingly there are efforts to conduct even detoxification on an outpatient basis. Outpatient detoxification appears to be possible now because of the availability of drugs (e.g., oxazepam) which can reduce physical withdrawal symptoms and medical complications. These drugs offer the opportunity to provide detoxification without intensive and costly hospitalization.

The analysis for OTA found that over the past decade a substantial effort has been undertaken to understand alcoholism and its treatment. We identified about 100 well-designed studies of alcoholism treatment programs and a number of reviews of studies of varying methodological quality. There are so many treatments available that specific conclusions are difficult to make. Most research investigates a package of treatments making it difficult to determine which aspect of a treatment or setting is having an effect. On the other hand, since most inpatient treatment programs incorporate a number of treatment modalities, the research literature is a fair representation of the real world. In some cases, adequate research is still not available to aid directly policy decisions about the most appropriate treatment or length of treatment. Research on alcoholism is still at a far lower level than needed and proportionately less than research for other health problems. Available research does, however, suggest the direction that policy and research should take.

OTA examined the overall research evidence, the evidence for inpatient versus outpatient treatment, the evidence for different treatment modalities, and the evidence for individualized treatment. Our testimony will emphasize the evidence for inpatient versus outpatient treatment because the appropriate locus of treatment is a major concern of S.2514.

Overall conclusions

Briefly, in line with previous research reviews, OTA concluded that any treatment for alcoholism is better than no treatment. From 45 to 63% of patients in the studies reviewed showed significant improvement although few maintained abstinence for very long. As for distinctions among different types of treatment, methodological problems make it difficult to conclude that any specific treatment is more effective than any other.

Inpatient v. Outpatient treatment. Perhaps the most important and controversial treatment issue concerns the use of inpatient v. outpatient treatment settings. The necessity for hospitalizing alcoholics -- that is, providing treatment over and above that necessary for detoxification or dealing with medical complications of alcohol abuse -- is both a substantive problem (relating to treatment goals and effectiveness) and a significant policy problem (because of the high costs associated with hospitalization). Unfortunately, assessments of the effectiveness of particular settings are difficult to separate from the effectiveness of treatment modalities. The setting of treatment is only one factor influencing treatment effectiveness.

Studies that have tried to separate the effects of treatment setting from the treatment modality have found that when a simple inpatient-outpatient dichotomy is used, inpatient treatment does not seem to be superior to outpatient treatment. The most interesting and potentially important finding, however, is that the inpatient-outpatient distinction is probably not very useful. One review which attempted to distinguish systematically the characteristics of studies reporting very good, good, intermediate, poor and very poor outcomes concluded that the inpatient unit was a valuable asset to a treatment program. However, it also concluded than an inpatient setting without an intensive community milieu and aggressive outpatient followup would be of limited value. The studies reporting very good outcomes were also characterized by a variety of other characteristics: considerable use of Antabuse to sensitize drinkers against alcohol, social casework, family therapy, involvement of employers and behavioral therapy.

Individualized treatment. With respect to which treatment modalities are effective, the data are again inadequate. It appears that treatments, such as aversion therapy (use in a numaber of proprietary alcoholism treatment facilities) are effective for some patients, but not all. According to the Rand studies of alcohol treatment, only 7% of alcoholics were able to achieve complete abstinence over a four year followup period, but about half of those who sought treatment were able to eliminate the serious problems caused by their drinking. The long term results of other studies which reported that drinkers could be taught to drink normally have recently been called into question and complete abstinence is usually a goal of most treatment programs. Such a goal may make it difficult for some to enter and remain in treatment. Since most established treatment settings employ multiple treatments, it is likely that a broadly focused treatment program is most desirable. Because alcoholism has several distinct origins, it is clear that treatments need to be individually based. Research is just beginning on how best to tailor treatments to individual needs. However, because we know that alcoholism has several components, it should be possible to design treatment programs around the central problem of an individual.

Implications for the "Veterans Health Care Amendments of 1984."

The thrust of S.2514, the "Veterans' Administration Health Care Amendments of 1984," as it concerns alcohol treatment and rehabilitation is generally consistent with our assessment of research findings. The bill establishes outpatient options such as halfway houses, and ensures development and implementation of treatment plans requiring long-term followup. These elements, based on current knowledge of alcholism treatment, appear to be cost-effective treatment solutions. Their application by the Veterans' Administration should assist in providing treatment to those in need of services and reducing the overall burden of health care treatment and costs within the Veterans' Administration.

Intermediate care facilities, such as halfway houses, may be particularly useful for alcoholics who do not have community roots and for whom supervised living is necessary if they are to develop and maintain skills to deal with problems associated with alcohol abuse. After detoxification, there may be no need for them to be in medically oriented inpatient facilities. The availability of halfway houses as a treatment option may be a means of providing the patient with needed services, but at a far lower cost than would be the case in a hospital setting. We are told that the average cost for such facilities is $21 per day, compared to $200 per day for inpatient care in a Veterans Administration hospital. The key to the success of a halfway house is probably the degree to which treatment services -- group and individual therapy, supervision of antabuse, and job skills training etc. -- are provided. However, it should be recognized that there are only certain individuals who are appropriate for halfway house services.

Perhaps the most important feature of the legislation, in terms of development of effective treatment, is the requirement that "...individual treatment plans are developed, implemented and monitored...". Recent research and literature on alcoholism treatment has stressed the need to tailor treatment to individual needs. Treatment planning is, thus, critical and should result in different treatment strategies for patients eligible for Veterans'

Administration services.

A related provision, that at least one year of followup monitoring of inpatients be required, also is consistent with present scientific understandings of alcoholism. Alcoholism is a chronic disorder with multiple origins. Treatment that is "frontloaded," in terms of being provided in intensive form upon identification of an alcoholism problem, probably has only limited effectiveness in terms of dealing with the various factors responsible for the alcoholism problem. Although only limited contact with a patient may be needed over time, continued care seems essential in order to provide effective treatment. One concern we have about S.2514 is that it does not provide for outpatient treatment for veterans who would not be suited to a halfway house facility. Our understanding is that it is often difficult to obtain followup outpatient care at Veterans Administration facilities. Because alcohol and drug abuse are not regarded as service-connected, discharged inpatients who are unable by reason of logistics to continue outpatient treatment in a Veterans Administration facility are often lost to further treatment.

Although, in general, the provisions of S.2514 seem wholly reasonable and likely to result in improved treatment of alcoholism by the Veterans' Administration, several provisions are potentially problematic. In particular, the establishment of maximum periods of treatment for specific settings may be inconsistent with provision of effective services. Setting a maximum treatment period in a halfway house of 60 days may be far too short. Halfway houses generally keep patients for 3 to 9 months and while that may appear a long time, it may be necessary for individuals who have no established social connections. It may be far less expensive to provide such services, particularly since it also allows patients to work and earn income, than to risk relapse.

Similarly, the establishment of maximum periods of treatment for particular forms of treatment may be counterproductive and difficult to do well. A potential problem is built into the provision requiring the Veterans Administration to designate maximums consistent with the average periods of such treatment and rehabilitation experienced in programs not administered by the Veterans Administration. Averages are not necessarily indications of optimal lengths of stay. It is inevitable that the average periods of treatment uncovered by Veterans Administration research will reflect a number of factors not necessarily related to good treatment such as patients' tendencies to drop out of treatment early and the effects of insurance coverage provisions, neither of which is based on what is optimal for patients. Further, establishment of maximums, irrespective of the treatment problem and condition of the patient, may result in overutilization of services or in individuals being released prematurely. Since the failure to provide effective treatment may be the most costly outcome, such maximums may serve to reduce alcoholism treatment costs while raising other health care expenditures. Although maximums may look cost-effective in the short run, in terms of total VA expenditures and in societal terms, they may not be beneficial.

Finally, the Amendments' requirement that a survey of all Veterans' Administration alcohol and drug treatment and rehabilitation programs be conducted and submitted to the Committee on Veterans' Affairs seems to be a worthwhile provision. The survey, however, would be much more valuable to the Veterans Administration and to alcoholism research in general if it were to include information about patient outcome. At present, major efforts are being undertaken to understand the nature of alcoholism and various treatments. Biological, psychological, and social research is being conducted at an unprecedented pace. Our knowledge of effective treatment will, almost surely, change during the next several years. It is important that the Veterans' Administration both be a participant in this process (i.e., support research on its treatment efforts) and utilize the results of research conducted elsewhere. Adding patient outcome data to the survey would allow the Veterans Administration to assess systematically the effects of changes in its approach to treatment, such as the contracting for community based facilities, compared to its other types of treatments.

Thank you for the opportunity to present our views. We would be happy to answer any questions you may have.

Chairman SIMPSON. Now, Ms. Hill.

Ms. HILL. Thank you, Mr. Chairman. My testimony today concerns the experience of the Baltimore Alcoholism Treatment Center in its efforts to provide services to a large population of alcoholics over the past 12 years. It is my hope that through our experience, you will better be able to address the concerns that now confront you in providing services for veterans.

The Baltimore Public Inebrian Program was the original name for the Baltimore Alcoholism Treatment Center. It consisted of a screening and evaluation unit, a small detoxification unit and a therapeutic community, originally funded by an NIAAA public inebriate grant. In addition, there was funding through a State grant.

Like most such programs, this program was designed to provide warmth, safety, and a level of personal comfort, and an access to public welfare and health services to alcoholics who were chronic, recidivist and therefore not expected to show much improvement. Our clientele then consisted largely of alcoholics whom others might regard as hopeless.

Also like most such programs, ours provided little structure or formalized plan for making actual changes in patient behavior, lifestyle and attitude. Relapse rates were high and few achieved any lasting recovery.

In the midseventies, however, our approach to treatment began to change. We established guidelines which prevented use of our facility as a flophouse to sleep off intoxication. We instituted an education program designed to teach the patient about his illness. We changed our philosophy substantially. Rather than focusing on the social consequences of alcoholism, we began to focus on getting the alcoholic to do something about his drinking.

In 1980, all services were consolidated under central management. The name and focus of the shelter was changed to reflect its new emphasis on initiating effective treatment of alcoholism, now seen as a chronic, progressive disease.

This component is now referred to as Baltimore Alcoholism Treatment Center Residential Treatment Services. Residents who relapsed or used alcohol again, were required to reenter the detox unit for 7 days. When they returned, they revised their treatment plans to prevent further relapse.

The treatment program is based on the chronic disease model set out to accomplish four simple but essential objectives: To teach the alcoholic patients what alcoholism was and how their disease worked; to get patients to self-diagnose, that is to recognize their own illness; to teach them how to use AA and other self-help groups; having learned this, to take personal responsibility for their own sobriety on an ongoing basis.

The program required attendance at all activities. If the resident failed to comply with treatment or showed no effort toward recovery, other living arrangements were found. Residents were told that though they had made no conscious choice to become alcoholic, they nonetheless were now responsible for treating their illness. AA had shown that even indigent, poorly functioning, debilitated alcoholics can recover, if they followed a few simple directions.

The treatment program took the position that the residents were there to get better, not simply to keep relapsing, and that AA and treatment were the way out.

The effectiveness of the model becomes clear in light of the incidents of relapse in the resident population. Before the change in the treatment approach, there was an average 89 referrals which was made up of 34 individuals a month to the screening unit for drinking. In fiscal 1983 there was an average of 10 referrals, made up of 10 individuals a month, to the screening and detoxification unit for drinking. There has been a 890-percent decrease in the number of incidents of relapse and a 340-percent decrease in the number of individuals who relapse.

We attribute our success entirely to the adoption of structured, chronic disease model treatment.

We also believe that your population, like other alcoholics, would benefit dramatically from the adoption of a similar structured treatment format.

Thank you very much.

[The prepared statement of Sandra K. Hill, R.N., C.A.C, M.B.A., director, Suburban Hospital's Alcoholism Treatment Services, Bethesda, MD, and president, board of trustees, Baltimore Alcoholism Treatment Center, Baltimore, MD, follows:]

PREPARED STATEMENT OF SANDRA K. HILL, R.N., C.A.C., M.B.A., DIRECTOR, SUBURBAN HOSPITAL'S ALCOHOLISM TREATMENT SERVICES, BETHESDA, MD, AND PRESIDENT, BOARD OF TRUSTEES, BALTIMORE ALCOHOLISM TREATMENT CENTER, BALTIMORE, MD

Distinguished Committee Members:

My testimony today concerns the experience of the Baltimore Alcoholism Treatment Center in its' efforts to provide services to a large population of alcoholics over the past 12 years. It is my hope that through our experience, you will better be able to address the concerns that now confront you in your own sector.

B.A.T.C. originally consisted of an Evaluation/Screening Unit, a Detoxification Unit, a Shelter, and a Therapeutic community, and was originally funded by an N.I.A.A.A. public inebriate grant. Like most such programs, B.A.T.C. was designed to provide warmth, safety, a modicum of personal comfort, and access to public welfare and health services to alcoholics who were chronic, recidivist, and therefore not expected to show much "improvement". Our clientele, then, consisted largely of alcoholics whom others might regard as "hopeless".

Also like most such programs, ours provided little structure or formalized plan for making actual changes in patient behavior, lifestyle, and attitude. Relapse rates were high, and few achieved any lasting recovery.

In the mid' 70's, however, our approach to treatment began to change. We established guidelines which prevented use of our facility as a "flophouse" to sleep off intoxication. We instituted an education program designed to teach the patient about his illness. We changed our philosophy substantially: rather than focusing on the social consequences of alcoholism, we began to focus on getting the alcoholic to do something about his drinking.

We initiated a "street rescue" program, which enabled us to identify and intervene with alcoholics before they managed to wander into our facility. This meant that we were able to find and treat patients before they became so ill that they were beyond medical help. After they were treated medically, we arranged to pick them up at the hospital and transport them to appropriate treatment. This service now operates on Friday and Saturday nights. At one time, CETA positions provided more extensive coverage.

In 1980, all services were consolidated under central management. The name (and focus) of the Shelter was changed to reflect its' new emphasis on initiating effective treatment of alcoholism, now seen as a chronic, progressive disease.

This component is now referred to as B.A.T.C. Residential Treatment Services. Beds were reduced in number from 83 to 74, and staff increased. Residents who relapsed (used alcohol again) were required to re-enteer the Detox Unit for 7 days. When they returned, they revised their treatment plans to prevent further relapse.

A Treatment Program based on the chronic disease model set out to accomplish four simple but essential objectives:

1. To teach alcoholic patients what alcoholism was, and how their disease worked.

2. To get these patients to "self-diagnose": that is, to recognize their own illness.

3. To teach them how to use AA and other self-help groups.

4. Having learned this, to take personal responsibility for their own sobriety, on an ongoing basis.

The Program required attendance at all activities. If the resident failed to comply with treatment, or showed no effort toward recovery, other living arrangements were found. Residents were told that though they had made no conscious choice to become alcoholic, they nonetheless were now responsible for treating their illness. AA had shown that even indigent, poorly functioning, debilitated alcoholics could recover, if they followed a few simple directions. The Treatment Program took the position that the residents were there to get better--not simply to keep relapsing--and that AA and treatment were the "way out" for any sick alcoholic.

As a result of these changes, the climate at B.A.T.C. has become completely different. Even this "hopeless" population has responded to these simple expectations. Patients who would previously have relapsed often stay sober. As a result, they make more consistent gains in treatment. Their health is better, as a result of the disease model's emphasis on health care. The local AA community has responded favorably to these changes and has worked hard to assist indigents in achieving sobriety.

As patients get better, they become less dependent on the facility and on the public welfare system. Many become employed in both private and public sectors. Others volunteer to help newcomers. Everyone, not matter how impaired, finds something he can do.

This would not be surprising result in any middle-class area, but it is unusual to find any method so effective with this population.

The effectiveness of the model becomes clear in light of the incidents of relapse in the resident population. Before the change in the treatment approach there was an average of 89 referrals (34 individuals) a month to the screening unit for drinking; in fiscal 83 there were an average of 10 referrals (10 individuals) a month to the detoxification unit for drinking. There was been a 890% decrease in the number of incidents of relapes and a 340 % decrease in the number of individuals who relapes.

We attribute our success entirely to our adoption of structured, chronic disease model treatment.

We also believe that your population, like other alcoholics, would benefit dramatically from the adoption of similar philosophy and methods.

Our conclusion: many alcoholic treatment "failures" occur because the patient was not treated effectively in the first place. Most alcoholics, no matter how deprived of family, friends, or fortune, will respond to effective, ongoing treatment.

We believe the veteran population would respond positively, as well.

The choice is yours.

ADDITIONAL INFORMATION

Based on Fiscal 83 data

	Evaluation	Detoxification	Residential
Sex:			
male	96%	85%	100%
female	4%	15%	
Age:			
21-39	28%	30%	22%
40-59	58%	56%	51%
60 +	14%	14%	27%
#Individuals Served:			
	2,704	1,066	128
Average Length of Stay:			
	5hrs	7days	6.5months
Cost:			
	$8.34per intake	$32.74 per pt/day	$14.34 per pt/day

Note: An intensive 28 day Alcoholism Treatment Program is being open this month to treat a broader population, that is; some patients with jobs and families intact.

The cost per day in the ATP is projected to be $35.00 per day.

Chairman SIMPSON. Mr. Ruffing please.

Mr. RUFFING. As a representative of the Halfway House Association, I appreciate the opportunity to address the issue of utilization of halfway houses and recovery homes by the Veterans' Administration. My involvement with veterans' chemical dependence goes back to 1957 when I did some volunteer work at the veteran's hospital in Biloxi, MS. In graduate school, I was involved in some research with Dr. Mary Ellen Curtin and George English at the veterans' hospitals in Louisville and Lexington, KY. In my doctoral programs, I did some work at the Federal prisons in Lexington, KY, and other places.

The impressions I have and the literature that I read and the research I have been involved with show that most of the veterans that we encounter at the halfway houses are the type that Dr. Saxe referred to, those who have been disconnected with families, community-base sources, and things that can enable them to get a support system going to recover.

And there are a few issues involved in these things that are being discussed today about halfway houses. One of them is that many of the people we see really do not need an inhospital setting, that the Veterans' Administration or other groups like this would contract with what has been established as a nonmedical or social detox, that a lot of these veterans can go directly from detox units to a halfway house or some facility like that, which is not a hospital.

They are quite cost effective in that the rate varies, that I know, from about $16 a day to $28 a day around the country, depending on the location. The ones in the immediate area run pretty close to $17 to $21 a day and a lot of them are $19 a day, as compared to $8,000 to $9,000 a month for inhospital treatment, not counting the physicians services, which very often are not needed.

One of the issues was restricting the service in hospital or in halfway houses to residentials to 60 days and it is not very practical, because a lot of the studies have shown, and in the paper I have submitted, Dr. Simpson shows that the treatment of alcoholics or the recovery of alcoholics is interjected by periods of relapse and they are identifiable periods of 5 to 7 weeks. And a lot of people come out of a treatment center right in the middle of or the beginning of a very high risk period, whereby it is indicated that a long-term stay, a longer term of 5 to 7 to 9 months would be indicated in a halfway house and get them over these periods and they stand a better chance of avoiding a relapse.

One question that I was asked was about the duplication or the cost duplication by the contracting of VA services. The VA in some places has set up separate licensures and standards and I think they could do a lot of cost saving simply by accepting the State licensure procedure in effect in many places. And I looked around and in some of the States I looked at, the State standards have been adapted to and sometimes exceed the ones set by the Veterans' Administration, they are copied after the Joint Commission on Hospital Accreditation, JCAH. So the standards are pretty high and doing something about the problem of alcoholism, anything that is done is better than nothing.

Ken Eaton, when he was working with Dr. Chafitz said in about 1971 or 1972 that if we do not solve the problem of alcoholism, no matter in our veteran population or our general population, we can forget about the rest of the problems that we have, because this is one that has the capacity to destroy the Nation.

Thank you very much.

Chairman SIMPSON. Rather dramatically said and I tend to believe that. I really do. Everything around here is dramatically said, but that was appropriate. I don't know, I practiced law for 20 years in a little town Coyote, WY, and if there were that many butchered human beings in Coyote, WY, there are that many anywhere in the world and that is what we forget in this place, that there are places where these people are not affected, there are restrictions there, and that is not true as long as there are human beings in other places, child abuse, butchered marriages.

[The prepared statement of Leo Ruffing, member of the board of directors, Association of Halfway House Alcoholism Programs of North America, Inc., St. Paul, MN, follows:]

PREPARED STATEMENT OF LEO RUFFING, MEMBER OF THE BOARD OF DIRECTORS, ASSOCIATION OF HALFWAY HOUSE ALCOHOLISM PROGRAMS OF NORTH AMERICA, INC., ST. PAUL, MN

The Association of Halfway House Alcoholism Programs of North, Incorporated (AHHAP) came into existance in 1966.

The Association comprises 233 full members, individual recovery homes/halfway houses, 26 associate members, and 212 individual members throughout the United States and Canada. In addition, it has a worldwide correspondent's list of 684.

We would like to address the following issues in light of proposed legislation:

I. Program Effectiveness
    A. Clinical Justification
    B. Productivity Factors

II. Cost Effectiveness
    A. Treatment Program Comparisons
    B. Self Sustaining Factors

III. Acceptance of State Licensure
    A. Standards Maintained/Improved
    B. Cost Decrease
    C. Utilization of Resources

IV. Proposed Reduction In Contract Period
    A. Clinically Unsound
    B. Potential For Increased Costs

V. Extention of Services to Include Social Detox, Three-Quarter Way Houses
    A. Cost Effectivess
    B. Utilization of Resources

Recovery from alcoholism and other drug addictions takes a minimum of two to three years. Recovery involves the whole person; the physical being, the psychological, emotional being, and the spiritual being.

Therefore, a multi-disciplined approach is essential in the delivery of service to individuals involved in a recovery process. This process should involve all community resources which provide delivery of health care services in what is termed a "continum of care". This means that a recovering person should have access to and benefit of a therapeutic team approach that encompasses all available community resources.

Dr. R. Keith Simpson, former Director of the Harrison Treatment Center in Des Moines, Iowa stated in 1968: "We can now predict with some definite degree of accuracy periods within the two year follow-up, that a person will have difficulties that may trigger relapses. I refer to it as a physiological phenomenon which can be diverted. These periods are: 5 to 7 weeks after the last drink; 5 to 7 months, 11 to 13 months and 18 months after the last drink. Preparing the patient for these periods relieves him of a lot of unnecessary fears and anxieties."

Common sense should tell us to keep the man or woman until they are through the crisis periods and then discharge them with encouragement and support; along with complete confidence in their ability to make it.

Most residential treatment facilities (Post Detox) are designed for 28 to 45 days. This forces the client to be discharged during the first or most intense crisis period described by Dr. Simpson. A person leaving a residential facility after 28 to 45 days most often returns to the same environment and circumstances from which they come. The recidivism rates and related cost increase (for re-entry into programs) are well documented.

Residents in a Halfway House/Recovery Home are most often open ended or developed for a 2 to 9 month stay. They are generally located in an area where all community services are available to their residents. (Employment opportunity, communty health service, educational facilities, AA, NA, and other self-help groups).

In half-way houses and three-quarter way houses, between 40 and 75% of the residents are employed and in some instances contribute as much as 60% to the cost of their treatment. Obviously, the cost of social services benefits are markly decreased in these populations as compared with residential treatment populations.

I would refer you to the table of cost comparisons for an overview of per diem costs and re-emphasize the self-sustaining nature of an employed client population.

Since their VA contract began 1 January, 1984, forty-nine veterans have gone through the Nu-Way House program. Ninety-eight percent of the veterans leaving the program were employed upon completing the program. A follow-up is completed 6 months after the veterans leave the program. Nineteen veterans were contacted as the follow-up directed. Of the nineteen veterans contacted; thirteen reported being sober, employed and reported an improved life style and feeling well about themselves.

AHHAP proposes that Veteran's Hospital contracting officers accept the licensure of Halfway Houses/Recovery Homes by state licensing authorities for substance abuse. In each state that we have checked, the state licensure was based on standards established by the Joint Commission on Hospital Accreditation (JCAH). These standards exceeded standards set by the Veteran's Administration. The requirement for dual inspection and dual standards only add to the work load and increases costs.

Another issue is whether or not the Veteran's Administration should continue to contract for sixty days with an option of a thirty days additional stay in the Halfway House/Recovery Home.

A study conducted by General Services Office of Alcoholic Anonymous some years ago, showed that "the longer a person stayed sober the more likely they were to stay sober". Individuals in the recovery process should be given every opportunity possible to prevent relapse and continue their recovery. Again recidivism and re-entry into treatment means double/triple costs. Treatment plans are developed on an individual basis, needs of individuals vary. AHHAP recommends continuance of the ensuing policy of sixty days residence with thirty days option.

AHHAP would also strongly recommend that the Veteran's Administration expand services to include the contracting for social detox units (non-medical models) and funding residents in three-quarter way houses.

Many individuals can go directly from 5 day social detox services to halfway houses with no need of the increased expenditure required by 28 to 45 day treatment programs. Contiuum of care then to be provided by three-quarter way houses would insure maximum recovery potential in the most cost effective manner.

In addition, the structure of social detox units, halfway and three-quarter way houses releases medical care providers and clinical personnel from providing unwarrented treatment and frees them for required participation in critical cases. In short, this proposal allows more individuals the opportunity to recover at the least cost.

In summary, halfway houses work; they are cost effective; state licensure would further decrease costs; a sixty to ninety day contract is clinically sound and has proven cost effective; expansion of services to include three-quarter way houses and social detox would increase overall productivity of the system of recovery.

Cost Comparisons

For Profit Treatment Facilities

Facility   Dollar Increase   % Increase

ARCV, Serenity Lodge, Maryview Hospital, Riverside Hospital, in-patient fees only, does not reflect medical fees.

1984 Contract $195.00/day
$90.00 86%
1982 Contract $105.00/day

Not For Profit Treatment Facilities

Facility   Dollar Increase** % Increase

Nu-Way House, Minneapolis, Mn.

1984 Contract $16.34/day
5%
1983 Contract $15.50/day   41%
34%
1979 Contract $11.55/day

Serenity House
Newport News, Va.

1984 Contract $18.00/day   No Increase
1979 Contract $18.00/day

Flynn Christian House
Portsmouth, Virginia

1984 Contract $19.00/day
12%
1980 Contract $17.00/day

**
$0.84 - NU-Way House 1983-1984
$3.95 - NU-Way House 1979-1983
No Increase - Serenity House no increase 1979-1984
$2.00 - Flynn Home 1980-1984

Chairman SIMPSON. Let me ask you this, it is of interest to me, you talked about new things and innovations and so on, how do you deal with the rock hard organization, which I think still must be the touchstone of alcohol rehabilitation, Alcoholic Anonymous? Are you still using Al-Anon, Alateen, and AA in great forms?

Ms. HILL. Speaking for our center, we in addition to having inpatient treatment in a halfway house, we also have a freestanding medical base detox, but we involve AA very much in providing meetings and facilities, having its sponsors helping with transportation and we regard being involved in AA as paramount in aftercare for patients to remain abstinent.

Chairman SIMPSON. Let me ask that of Dr. Saxe. I have a rollcall vote. I must leave. I will leave the chief counsel and staff director to continue. I do not like to do that, but I have about 7 minutes before the vote. But I am interested in AA, Al-Anon, and Alateen.

Dr. SAXE. Unfortunately, there are no data to indicate their effectiveness. There is no research on it. It is clear that for a lot of people it helps them maintain sobriety. AA does not consider itself a treatment. It is clear for a lot of people that once they have been able to achieve sobriety through a treatment program that AA and the other organizations help their family members and so on. They are very important, but it is not a substitute for treatment.

Chairman SIMPSON. Mr. Ruffing.

Mr. RUFFING. I just avoid that. I am a recovered alcoholic who has been abstinent since 1957 and I avoid answering a question like that.

Chairman SIMPSON. You are going to skip that. That is very interesting. Those are the most effective people to the alcoholic. You cannot talk the talk unless you have walked the walk. I just wonder too if there is still the emphasis on the group therapy, group interactions, group encounters. Is that still very much a part of the program?

Dr. SAXE. Most treatment programs that I am aware of incorporate a variety of components in which group therapy as well as individual therapy, and so on, are a piece of it. The data indicate that the programs that have lots of those elements, that maintain contact with the patient over time are the ones that lead to the most successful outcomes.

Chairman SIMPSON. The old support system found in there.

Dr. SAXE. As long as it is overtime, yes.

Mr. RUFFING. Even posttreatments and aftercare, everyone I know anything about uses a group method.

Chairman SIMPSON. In your research, doctor, has the VA been of assistance to you, offered you help on this?

Dr. SAXE. In our initial work, we had a bit of a problem finding out what goes on in the VA, in part because it is so decentralized. Each VA has their own program and they vary very widely. Some centers do not have programs, some do have programs and some centers involve outpatient care. My sense is that in general, treatment is inpatient based, not community based, not a long-term followup based system.

That is one of the reasons why in our full testimony we strongly encourage the conduct of the survey that is appropriated in S. 2514, that collecting some data on what the VA does would be the first step to improving their treatment.

Chairman SIMPSON. Well, it is an area that has always intrigued me, because it is indeed, I think, the greatest social problem and the interesting thing to me always in my long-term dealing with it, and that is that that is the greatest abused drug in the United States and we do not treat it that way.

We shield it and socialize it and make it pretty jazzy stuff, but it is the most abused drug in the United States. The sooner we get to putting our priorities on it in that way, we will make progress in the VA or whatever.

Anyway, thank you. I really regret leaving. I will be back. Tony, if you will go forward. Thank you so much for being here.

Mr. PRINCIPI. The chairman had to leave for a vote on the Senate floor on a health-care issue.

Dr. Saxe, I just have one question. During your research on the OTA report on the "Effectiveness and Costs of Alcohol Treatment," what specific information did you receive from the Veterans' Administration that aided you in the development of the report?

Dr. SAXE. As I indicated to the chairman before he left, we did not get much in way of specific information. We got information about specific programs. There are some very well-known scientists and people who have done important research at different VA facilities and all I can do at this stage is give you an impressionistic view, that there was not a centralized program across the country and that the services available to veterans at various facilities differ greatly, depending upon the location, proximity to a particular facility, et cetera.

Denise, do you want to add something?

Ms. DOUGHERTY. We looked at research studies and how it was conducted, especially in VA facilities but we did not sort them out.

Mr. PRINCIPI. Thank you. Ms. Hill, what specific recommendations could you offer the VA that might aid them in their efforts to provide alcohol treatment?

Ms. HILL. I think the concept of having community-based treatment is very important and providing a structured groundwork and treatment in the community and allowing those people to return to the community after the initial treatment. What we have found effective with a large indigent population is a structured treatment format as opposed to looking at the problems of alcohol in terms of societal problems and looking at the problems of alcohol in terms of physiological problems and basing it on a chronic disease model of treatment.

Mr. PRINCIPI. Mr. Ruffing, I have one further question. What specific efforts has the VA made to monitor your efforts to provide halfway house programs to eligible veterans? For example, how many of your programs have been contacted by the VA since the program was begun? How has the contact been done, by phone, visits, in writing, and what has been the frequency of such contact?

Mr. RUFFING. I was just contacted about 4 days ago to come here and I just do not have that broad of information, but I know, I talked to several people. I talked to the New Way House in St. Paul, MN, and one or two others and the Veterans' Administration contract requires a 6-month followup on each veteran after he leaves the program.

They require employment status, self-reporting on life style, self-reporting on how they feel about themselves and that kind of thing. I know, I am associated with a home in Portsmouth, VA and I know in the last 6 months we have had three visits from the Veterans' Administration and we have some reporting to give to them.

Mr. Anderson is with the Serenity House in Newport News, VA, and he has Veterans' Administration contact. I do not know how often his contact is.

Mr. PRINCIPI. I would appreciate hearing from Mr. Anderson. But, Mr. Ruffing, could you provide specifics of the question for the record. We will provide you with the question. Would you provide us with the specifics on the number of times your program has been contacted by VA and more specifics with respect to the monitoring of the program.

Mr. RUFFING. I just do not have that information, I am sorry, not off the top of my head.

Mr. PRINCIPI. Thank you. Mr. Anderson.

Mr. ANDERSON. I am the director of the Serenity House in Newport News. We are contacted on a monthly basis by a VA hospital in reference to the contracts. In some months it is done by telephone, but at least quarterly, we have a visit from the VA hospital staff. The staff of the VA hospital will contact us on each one of their contracts on a monthly basis, not just contact the program, but they will specifically discuss each one of their clients and their treatment plan to ensure that the treatment plan is visualized and that the followup is taking place.

Mr. PRINCIPI. Thank you very much for your testimony.

[The responses of Leonard Saxe, Ph.D., assistant professor, Department of Psychology, Boston University, Boston, MA; Sandra K. Hill, R.N., C.A.C., M.B.A., director, Suburban Hospital's Alcoholism Treatment Services, Bethesda, MD, and president, board of trustees, Baltimore Alcoholism Treatment Center, Baltimore, MD; and Leo Ruffing, member of the board of directors, Association of Halfway House Alcoholism Programs of North America, Inc., St. Paul, MN, to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, follow:]

RESPONSE OF LEONARD SAXE, PH.D., ASSISTANT PROFESSOR, DEPARTMENT OF PSYCHOLOGY, BOSTON UNIVERSITY, BOSTON, MA, TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. WHAT SPECIFIC RECOMMENDATIONS COULD YOU OFFER TO THE VA THAT MIGHT AID THEM IN THEIR EFFORTS TO PROVIDE ALCOHOLISM TREATMENT?

Answer 1. It is not clear the extent to which the VA regards alcoholism as a major problem and a significant factor in the cost of VA health services and quality of health care provided veterans. Acceptance of the magnitude of the alcoholism problem is the first step to developing better strategies for dealing with the alcoholism problem and providing treatment. This acceptance should lead to a willingness to provide additional resources for treatment programs and better integration of alcoholism treatment within the VA.

A second specific recommendation is that the VA should develop procedures whereby any veteran eligible for VA services can obtain alcoholism treatment. At present, the availability of services depends on which facility a patient happens to be receiving treatment from. Some emphasize alcoholism treatment, others do not. No veteran should be denied treatment because of a lack of a treatment program or logistical problems (principally, the distance that must be travelled to reach a facility).

A third recommendation is that the VA reorient treatment services away from inpatient treatment to longer term outpatient care. The VA runs a number of very good inpatient treatment programs for alcoholism. Although such programs serve a vital function, they need to be coupled with long-term outpatient care. In many cases, such outpatient treatment can be substituted for much higher cost inpatient treatment. Numerous models of outpatient treatment are available and, given the diversity of the VA's patient population, there is probably no one best form of outpatient treatment. Treatment designed to provide patients with social support as well as counselling, and designed to deal with the chronic nature of alcholism, is required.

A fourth recommendation is that research, particularly focused on evaluation of treatment outcome, be supported. Neither the magnitude of the alcoholism problem nor the effectiveness of specific treatments for different patient groups is well-understood. Rigorous research is needed to improve our understanding of alcoholism and direct policy efforts.

Each of these recommendations is consistent with the thrust of S.2514. With consideration of some of the issues concerning treatment limits described in our statement, the legislation would appear to be an important step in developing more effective VA alcoholism programs.

Question 2. FOR THOSE WITH A HISTORY OF CHRONIC ALCOHOLISM, INCLUDING RELAPSES, WHAT, IN YOUR OPINION, IS THE KEY TREATMENT METHOD THAT SHOULD BE EMPLOYED TO MINIMIZE CHANCES OF RELAPSE AND MAXIMIZE CHANCES OF A SUCCESSFUL TREATMENT OUTCOME?

Answer 2. Probably no single treatment method can be employed to deal with chronic alcoholism. What is required is long-term followup, support, and counselling. Such services are usually labelled as "outpatient" treatment and include a wide range of actual treatments. Included may be drugs (in particular, disulfiram), group or individual psychotherapy, and support programs such as AA. Which treatment will be most effective will depend on the physical condition of the patient, as well as the patient's psychological and social situation.

Maximization of treatment outcomes is probably best accomplished by programs which enable followup of patients and incorporate a number of treatment options. Inpatient hospitalization should only be employed when absolutely necessary because of the patient's physical condition or inability to remain sober. Particular outpatient treatment options should be employed depending on the patient's social stability (e.g., patients without family and community ties may require placement in a halfway house or a day hospital) and level of psychological disturbance (e.g., severely disturbed patients may require individual psychotherapy).

Question 3. IN YOUR OPINION, WHAT ARE THE MOST CRITICAL COMPONENTS OF A SUCCESSFUL ALCOHOLISM TREATMENT PROGRAM?

Answer 3. The most critical components of an alcoholism treatment program are that it be coordinated and designed around the specific needs of a patient. The most important component is probably the integration of medical, psychological and social treatments. Alcoholism arises from a number of sources and its treatment needs to address, in a coordinated way, each of its etiological factors. Because, for different patients the causes may be different and their coping abilities vary, treatment needs to be individualized. In addition, because of the chronic nature of alcoholism, it is unrealistic to assume that a brief period of intensive treatment will eliminate the problem. Treatment needs to be regarded as long-term and supportive of a patient's readjustment to living without heavy alcohol use.

RESPONSE OF SANDRA K. HILL, R.N., C.A.C., M.B.A., DIRECTOR, SUBURBAN HOSPITAL'S ALCOHOLISM TREATMENT SERVICES, BETHESDA, MD, AND PRESIDENT, BOARD OF TRUSTEES, BALTIMORE ALCOHOLISM TREATMENT CENTER, BALTIMORE, MD, TO WRITTEN QUESTION SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1.

YOU HAVE STATED THAT THE AVERAGE LENGTH OF STAY FOR PERSONS IN YOUR PROGRAM IS SIX AND A HALF MONTHS. WHAT WOULD BE THE IMPACT ON THE LENGTH OF STAY IF A HALFWAY HOUSE PROGRAM WERE ADDED TO YOUR EFFORTS AND CARE WAS CLOSELY MONITORED THROUGH VARIOUS AFTER-CARE ALTERNATIONS FOR AT LEASE A ONE-YEAR PERIOD?

WHAT IS YOUR OPINION OF THE VALUE OF A PSYCHO-SOCIAL MODEL VERSUS A TRADITIONAL PSYCHIATRIC MODEL, ESPECIALLY FOR PERSONS WITH LIMITED FINANCIAL AND SOCIAL RESOURCES AND MULTIPLE MEDICAL PROBLEMS?

Answer 1.

Our program is in fact opening 2 new components: a 21-28 day Intermediate Care Program, and a 9-18 month Halfway House, to supplment existing Detox and Chronic Care facilities.

The 6½ month figure is the current average length of stay, rather than a recommended length of stay. As the 2 new programs have just opened, no date re: their impact on average LOS is available.

We believe that traditional psychiatric approaches have repeatedly failed in treatment of alcoholics and should be discarded. Many "psycho-social" models are equally useless, however, our experience is that a medical (rather than psyhiatric), chronic disease model is the most effective for any population of alcoholics. Psychosocial aspects are included in this model of treatment.

Question 2.

FOR THOSE WITH A HISTORY OF CHRONIC ALCOHOLISM,INCLUDING RELAPSES, WHAT, IN YOUR OPINION, IS THE KEY TREATMENT METHOD THAT SHOULD BE EMPLOYED TO MINIMIZE CHANCES OF RELAPSE AND MAXIMIZE CHANCES OF A SUCCESSFUL TREATMENT OUTCOME?

Answer 2.

To minimize likelihood of relapse, a treatment program must set out to change the attitude of the alcoholic towards his (or her) disease.

The program must then seek to educate the patient about the importance of ongoing treatment, making special use of self-help groups such as AA.

Changing a patient's attitude towards alcoholism is not the same thing as changing that alcoholic's attitude towards his childhood, parents, pervious behavior, and the like. It is a very specific task which must be addressed directly for treatment to be successful.

In most cases, "relapse" occurs not because the alcoholic is unable to stay sober, but because he allows other concerns --- money, past injustices, love, etc. -- to become more important that treating his disease.

As a result, he simply stops performing whatever activities which keep him sober: AA attendance, helping others, and the like. Soon, he relapses.

Since recovery is established through intensive medical intervention, education, and lifestyle change, an appropriate program structure is essential. The program must be organized, well-planned, and managed to prevent interference with accomplishing the central tasks of treatment. Structure must, therefore, maximize the impact of treatment on the patient.

Laissez-faire approaches, are inneffective with this type of patient, no matter what his background.

Question 3.

HOW STRUCTURED SHOULD A PROGRAM BE TO PROMOTE A SUCCESSFUL TREATMENT OUTCOME?

Answer 3.

Very structured. We attached a copy of the schedule of a typical 21-day treatment program --- from Suburban Hospital, in Bethesda. Notice that treatment resembles the kind of intensive educational experience that one might obtain in a specialized occupational training program. It is task-oriented, specific, and emphasizes practical application of knowledge.

We do not believe in "structure for its own sake", as Synanon might. Every activity in the program has purpose in treatment, and the structure simply makes sure the patient receives maximum benefit from time spent in treatment.

Question 4.

WHAT IS THE RELATION BETWEEN THE DEGREE OF STRUCTURE IN AN ALCOHOLISM TREATMENT PROGRAM AND THE RISK OF RELAPSE?

Answer 4.

Highly structured programs make a greater impact on their patients, and therefore have lower relapse rates. B.A.T.C.'s relapse rate decreased 800% after structure was added. Most treatment programs which feature a highly-structured, chronic disease model, AA oriented approach produce recovery rates 2-4 times those of other approaches.

Question 5.

IN YOUR OPINION, WHAT ARE THE MOST CRITICAL COMPONENTS OF A SUCCESSFUL ALCOHOLISM TREATMENT PROGRAM?

Answer 5.

To be successful, a treatment program must provide:

1. Medical Detox and care.
2. Comprehensive education about alcoholism.
3. Intermediate Care and treatment.
4. Halfway facilities for those who require them.
5. Access at all levels to AA.
6. Viable Aftercare and followup.

Question 6.

YOU HAVE SAID THAT YOU BELIEVE TREATMENT CAN RESULT IN SUCCESSFUL OUTCOMES EVEN FOR PERSONS WITH CHRONIC ALCOHOLISM.

WOULD YOU RECOMMEND THAT TREATMENT MODELS BE STRUCTURED DIFFERENTLY FOR PERSONS WITH FEW SOCIAL AND FINANCIAL SUPPORTS THAN FOR PERSONS WHO HAVE FAMILIES AND JOBS TO RETURN TO AT THE END OF TREATMENT?

Answer 6.

Dr. Vailliant's longitudinal studies indicate that most recovering alcoholics who lack financial, family and social supports replace these through intense involvement in AA and other fellowships. Without treatment designed to motivate such involvement, prognosis is guarded. Psychiatric or social welfare assistance without strong emphasis on AA is probably, as the saying goes, "throwing good money after bad".

Thus, indigent alcoholics require even more structured threatment for alcoholism than do middle-class alcoholics.

Attachment

ALCOHOLISM TREATMENT AND RECOVERY PROGRAM

21 DAY SCHEDULE

Week of:
WEEK #2

MONDAY-DAY 8	TUESDAY-DAY 9	WEDNESDAY-DAY 10	THURSDAY-DAY 11	FRIDAY-DAY 12	SATURDAY-DAY 13	SUNDAY-DAY 14
7:40 a.m. BREAKFAST (LR)	7:40 a.m. BREAKFAST (LR)	7:40 a.m. BREAKFAST (LR)	7:40 a.m. BREAKFAST (LR)	7:40 a.m. BREAKFAST	7:40 a.m. BREAKFAST	7:40 a.m. BREAKFAST
9a.m.-9:30a.m. COMMUNITY MTG.(LR)	9a.m.-9:30A COMMUNITY MTG.(LR)	9a.m.-9:30a.m. COMMUNITY MTG. (LR)	9a.m.-9:30a.m. COMMUNITY MTG. (LR)	9a.m.-9:30a.m. COMMUNITY MTG. (LR)	9a.m.-9:30a.m. COMMUNITY MTG. (LR)	9:00 a.m. LECTURE (LR)
10a.m.-11a.m. LECTURE (LR)	10A-11A LECTURE (LR)	10A-11A LECTURE(LR)	10a.m.-11a.m. LECTURE (LR)	10a.m.-11a.m. LECTURE (LR)	10a.m.-11a.m. LECTURE (LR)	10:00 a.m. CHAPEL (Optional)
11:15A-11:20A LUNCH (LR)	11:15A-11:20A LUNCH (LR)	11:15A-11:20A LUNCH (LR)	11:15A-11:20A LUNCH (LR)	11:15A-11:20A LUNCH (LR)	11:20AM LUNCH	12:20 PM LUNCH
1P-1:30P QUIET TIME	1P-1:30P QUIET TIME	12:10 P.M. AFTERCARE ORIENTATION (last week's patient)	1:PM-1:30P QUIET TIME	1:PM-1:30P QUIET TIME	1:00PM-2:00PM RECREATION	1:PM-2:PM RECREATION
1:30-2:30P STUDY GROUP (by teams) Red-Con. Rm. Blue-Lec. Rm.	1P-1:30P STEP 2 DISCUSSION GROUP (by teams) Red-Conf. Rm. Blue-Lec. Rm.	1:PM-1:30P QUIET TIME	1:30P-2:30P SELF-DIAGNOSIS GROUP (by teams) Red-Conf. Rm Blue-Lecture Rm.	1:30P-2:30P TREATMENT PLAN GROUP (by teams) Red-Conf. Rm. Blue-Lecture Rm.	3:30P-4:30PM RAP SESSIONS (by teams) Red-Conf. Rm. Blue-Lecture Rm.	5:20PM DINNER
4P-5P LECTURE (LR)	4P-5P LECTURE (LR)	1:30P-2:30P STUDY GROUP (by teams) Red-Conf. Rm. Blue-Lecture Rm.	4:PM-5PM LECTURE (LR)	4:PM-5PM LECTURE (LR)	5:20PM DINNER (LR)	7:00PM LECTURE (LR)
5:15P-5:20P DINNER (LR)	5:15P-5:20P DINNER (LR)	4:PM-5:PM LECTURE (LR)	5:15P-5:20P DINNER (LR)	5:15P-5:20P DINNER (LR)	8:00PM A.A. MEETING	8:00 PM A.A. MEETING
6:30P-7PM QUIET TIME	6:30-7PM QUIET TIME	5:15P-5:20PM DINNER (LR)	6:30P-7:00PM QUIET TIME	6:30P-7:00P QUIET TIME (LR)		
8:PM MEN'S/WOMEN'S GROUP MEN-Conf. RM. WOMEN-Library	7:00PM-8:PM AFTERCARE	6:30P-7:00P QUIET TIME	8:PM A.A. MEETING	7:PM-8:00PM AFTERCARE (LR)		
	8:00PM AA MEETING	8:00P A.A. MEETING	8:00P-9:00P CONCERNED PERSONS PROGRAM Conf. Rm.	8:30PM A.A. MEETING Conf. Rms. 1,2,&3 (next to cafeteria)		
		8:00P-9:00P CONCERNED PERSONS PROGRAM (Conf. Rm.)				

LR = Lecture Room

Conf. Rm. = Conference Room

8/81
abw

RESPONSE OF LEO RUFFING, MEMBER OF THE BOARD OF DIRECTORS, ASSOCIATION OF HALFWAY HOUSE ALCOHOLISM PROGRAMS OF NORTH AMERICA, INC., ST. PAUL, MN TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. How many halfway houses were contacted by the VA?

Answer 1. The pilot project authorized regional VA hospitals to contact halfway houses for contract services. The VA Washington Central Office supplied VA hospitals with lists of halfway houses and other residential programs. Multiple efforts were made to contact and involve halfway houses in 1979 and 1980. Now the availability of VA contracts for residential services is well known in the field.

Dr. Stewart Baker attended the last four AHHAP conferences and gave presentations and workshops on the particulars of the VA halfway house contract program.

Question 2. Are there outcome measures of success?

Answer 2. Halfway houses are limited in measuring the number of veterans who successfully complete the halfway house program. AHHAP, as an association, has not been able to collect positive completion data from all contract programs. The comments received from AHHAP member houses is that the positive completion rate for veterans is higher than for non-veterans.

The VA Central Office and the regional VA hospitals conducted nine months one year followup studies. These results have not been released to the public, but it is believed that the veteran success rate is high.

Question 3. How will permanent status affect the per diem rate?

Answer 3. The VA contracts with halfway houses are free market. If a program chooses to increase its fee, the new fee must be acceptable by the local VA hospital program. The free market nature of contracts assures the government that costs will remain reasonable and rise only as inflationary operating costs rise.

Officially, AHHAP has no position on making the VA contract program permanent or just a three year extension. When AHHAP holds its conference in May 1984, membership will be polled on this issue.

Mr. PRINCIPI. Dr. Smith, clinical program director appointee, Center for Trauma Recovery, Brecksville Division, VA Medical Center in Cleveland.

Dr. Smith.

TESTIMONY OF JOHN R. SMITH, M.A., CLINICAL PROGRAM DIRECTOR APPOINTEE, CENTER FOR TRAUMA RECOVERY, BRECKSVILLE DIVISION, VA MEDICAL CENTER, CLEVELAND, OH

Mr. SMITH. Thank you. I just want to clarify first that I have been peddling fast for a long time and I come from Duke University as does Dr. Busse. I am peddling as quickly as I can to get that Ph.D. As of today, I am still a mister but shortly it will be doctor.

I thank you for the opportunity to come. I come as the incoming Director for the Center for Trauma Recovery of Cleveland's VA Medical Center. I also serve as chairman of the Veterans' Administration Advisory Committee on Readjustment Problems of Vietnam Veterans. I also initiated the research on the Legacy of Vietnam study for this committee for the Veterans' Administration several years ago.

I have served on the committee for the American Psychiatric Association and drafted the entry on post-traumatic-stress disorder for the Diagnostic and Statistics Manual [DSM III]. I've also served, since the inception of the Vet Center Program, as a consultant. So, I am fairly familiar with what has been happening for a number of years with post-traumatic stress in the VA.

As is apparent here this morning, PTSD is one of a number of competing interests and problems among many that are at issue within the Veterans' Administration. All of the existing programs funded in PTSD come out of local initiatives at VA hospitals. At these centers, we have identified veterans with PTSD either by having a demonstration project at their doors, or by seeing through patient care, a need that has not been met.

The issue of post-traumatic stress has been a long time in development. It took us 8 years from the time of inception for us to get the funds and do the initial study, the legacy study that documented that there were in fact, readjustment problems. It was 7 years from the time we first raised the question that we were able to publish and officially recognize post-traumatic-stress disorders.

Although we had recognized PTSD as early as 1970, it was not until 1980 that we were able to finally achieve some formal recognition that this was a legitimate topic for inquiry and for research.

It was 9 years from the time the first proposal was made in the Congress for the creation of a readjustment counseling program, like the Vet Center, until there was a program created. It is now, as of last month, 10 years since the last American troops left Vietnam and we are only beginning to address the problem of post-traumatic-stress disorders.

As a result of our research, we have come to see that service-related problems in the fight for resources within the hospitals should be a priority. We have felt all along that if post-traumatic-stress disorder is not a priority service-related issue, it should not be allocated any other resources and any other treatments within the VA. We have come to see over the years that things like spinal cord injury, physical rehabilitation from wounds, and much of our research have demonstrated that post-traumatic-stress disorder is the single mental health issue that is a truly service-related problem. It is specifically and explicitly the domain of the Veterans' Administration.

Consequently, we have come to feel that post-traumatic-stress disorder should be a priority as a treatment among other competing interests within the VA. We have also learned a lesson over the years. Priorities are set by the allocation of dollars. When we mandate that there should be a center for traumatic stress recovery and we give it directive, if dollars are not attached to that, as happened in 1981 when this committee first recommended to the VA that they create such a center, we usually see little action.

As we saw in the long history of legislation about the legacy study, under the Vet Center Program, we saw that when in 1979 the Congress appropriated moneys, a Vet Center Program was created and we saw additional dollars within the Veterans' Administration begin to approve the treatment of those problems.

We also realized that most of the existing PTSD programs, aside from the Vet Center, are underfunded and understaffed. Because resources are limited, these programs do not do outcome evaluations or document whether in fact, as this last panel demonstrated which treatments are effective and which are not. We have not done that kind of evaluation research.

We have found that research dollars that might be allocated to research on post-traumatic stress are in fact committed long years in advance to recruitment and retention of physicians in the VA system, who engage in basic science and research, not in specific problems that are directly germane to the issue of the Veterans' Administration.

We see that education and training dollars are appropriated for a variety of causes and not particularly designated for post-traumatic-stress disorder. The questions of staffing of those units and what is appropriate has come out of what the local hospitals can provide and not on the basis of what is useful and necessary for its system to respond.

We saw very clearly that when the Vet Center Program was allocated dollars, the Vet Center Program was created. We saw that when there were management issues within the Veterans' Administration and there were dollars attached to it, the Veterans' Administration responded and a readjustment counseling service was created. So when we think about establishing an office for post-traumatic-stress disorder within the Veterans' Administration or a national center, what we really look at is what is the mandate from Congress? Is it a mandate saying you may create it if you desire? Or is it a mandate to multiply your loaves and fishes and say, well, if you have got any extra dollars left over, perhaps you can take care of these guys.

What we are looking at are the implications of creating a program that addresses the community resources issues? When we are talking about creating a center in Cleveland, OH for post-traumatic stress, we ought to address the problem local community services, because PTSD experts within and outside the VA have become very needed community resources.

Vet Center personnel in North Carolina, myself and others who have been treating Vietnam veterans have, for example, responded to the community by helping initiate similar treatment programs for tornado victims such as occurred last week in North Carolina.

The same was true for the victims of Buffalo Creek, and for the victims of the Beverly Hills Supper Club fire in Covington, KY. It was also, in part, Vet Center personnel who went to California to help the earthquake victims. So, programs in post-traumatic-stress disorder do not have any problem in serving as a community training resource since they are very much in need by the communities in which they exist.

When we talk about alcoholism programs, these and post-traumatic-stress programs work hand in hand because we have uncovered PTSD victims as we examine POW's who are reevaluated for treatment. Further, many veterans, since World War II or Korea, have substance abuse and alcohol problems that are related to post-traumatic-stress problems that are only now coming to attention and are being diagnosed.

We do not have any problems working in this capacity, because it is an essential enterprise within the VA and the services that are being offered address the particular needs of veteran populations. The question we ask is when, if we are talking about extending eligibility, if we are talking about creating a national center for post-traumatic stress or mandating an office, will we see the kinds of appropriations that are going to supplement these services? Not that they are going to be totally funded, but we see consistently that when there is at least a token allocation that says this is a priority from Congress, we see some movement in and we see effective management within the Veterans' Administration.

So, at a time 10 years later when we have thousands of veterans waiting for less than 300 post-traumatic-stress disorder beds, when new veterans are emerging out of hostilities and coming into the Vet Center Program from Lebanon and Grenada with post-traumatic-stress or readjustment problems, and when we are allocating increasing numbers of dollars for Federal defense, we ask the question about what is the value that Congress places on the problems of veterans from its previous wars. We look for the answer not only in mandates to create an office and new programs but also in the allocation and request for supplemental funds to initiate those kinds of programs.

Mr. PRINCIPI. Thank you very much.

[The prepared statement of John R. Smith, M.A., clinical program director appointee, Center for Trauma Recovery, Brecksville Division, VA Medical Center, Cleveland, OH, follows:]

PREPARED STATEMENT OF JOHN R. SMITH, M.A., CLINICAL PROGRAM DIRECTOR APPOINTEE, CENTER FOR TRAUMA RECOVERY, BRECKSVILLE DIVISION, VA MEDICAL CENTER, CLEVELAND, OHIO

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to appear before you today to comment on S.2514, the proposed "Veterans Administraion Health Care Amendments of 1984"; S.2269, the proposed "Veterans Administration Health Care Program Improvements Act of 1984"; and S.Amendment No. 2850 to S. 2269. I would like to address my remarks specifically to those issues relating to Post Traumatic Stress Disorders and Readjustment Counseling services. There are three such areas in the legislation I shall address.

ELIGIBILITY

I endorse the inclusion of active duty veterans who served during the Vietnam era. Currently numbers of such veterans are in need of readjustment counseling services and present for such services at existing Vet Centers near military installations. The legislation would clear up an existing dilemma for such Vet Centers in whether to serve these active duty veterans covertly or to deny needed couseling. Secondly it would provide a step toward resolving another ticklish problem. Currently several military mental health facilities skirt the general non-recognition of stress related problems by referring to Vet Centers or by providing readjustment counseling services covertly at night or off base. By making available a non-stigmatizing alternative, a neglected class of veterans can have a legitimate source of services while the dialogue over the existence of stress reactions in active duty personnel is moved closer to forthright discussion.

The inclusion of veterans from conflicts subsequent to Vietnam addresses several other important issues. The most important lessons we have learned from the investigation and treatment of stress reactions in Vietnam veterans is that such reactions are not confined to that era. Veterans from Lebanon have already appeared for assistance at Vet Centers. To recognize that some stress reactions are and will appear in later veteran generations does not mean that all such troops are stressed. It does confirm our understanding derived from initial work with Vietnam veterans that armed forces in the latter half of the 20th century will be at risk for such reactions. Work with Vietnam veterans has opened the mental health field to recognition of post traumatic reactions in assaults, civilian catastrophe and a variety of common stressful circumstances. Understanding the disorder has led to an insight into the normal process of integration of stressful experience whether undergone in combat or civilian life. Extension of services to this later group of veterans anticipates a need and enables an appropriate response.

Extension of eligibility serves another function also. It confirms the view of Congress that service related health problems such as PTSD should be a priority concern of the agency charged with meeting the needs of those who have borne the battle for the nation.

Problem: Extension of eligibility to veterans of conflicts subsequent to Vietnam highlights the continuing needs for PTSD and"readjustment" counseling services to veterans of earlier eras. For example, the excellent current outreach and evaluation efforts to POWs from several eras has begun to identify veterans with long neglected war related stress reactions which have been unrecognized as such for many years. New diagnostic methods and treatment alternatives developed for Vietnam veterans are now finding fruitful application with older veterans. Expertise honed in work with Vietnam increasingly is sought for consultation with WWII and Korean veterans long treated less effectively under other labels or for long standing drug or alcohol problems.

Recommendation: The Committee consider extension of eligibility for "readustment" and PTSD services to veterans of eras of hostilities both prior to and subsequent to Vietnam.

NATIONAL CENTER FOR PTSD

My endorsement for a Center for PTSD in the Veterans Adminsitration is not new. Three years ago in testimony before this Committee, I recommended consideration of the establishment of such a center. This Committee has suggested the creation of a center of excellence on PTSD on several occasions since that time.

The creation, evaluation, documentation and dissemination of treatment alternatives for PTSD is badly needed. Documentation of the successes and their reasons, as well as of the shortcomings of the Vet Centers and existing PTSD programs is vital to the primary mission of the VA. Education and training of health care personnel in PTSD will be a major need for the next several years. Research efforts in PTSD have barely begun and are presently poorly funded and coordinated.

Some would contend that shortcomings in knowledge on PTSD and lack of consensus on all research and treatment issues warrants a passive approach to PTSD treatment, research and education. On the contrary, scientific rigor and human compassion demand that efforts be initiated, supported and rigorously reviewed. Differences should be reduced to hypotheses, clinical trials initiated and the results disseminated to shape future policy. We have done no less for cancer, cardiology and even a recent disease many contended was a righteous curse on its victims, AIDS. In each case an active research and treatment effort has led to rapid advances. New questions always arise, but downplaying the problem for lack of answers or uniform treatment has never soved such problems. If we make such efforts for these problems, surely we cannot do less in the VA for a directly service related problem of such proportions as PTSD.

More broadly, experts in PTSD with Vietnam veterans have for years served more broadly as community resources in civilian PTSD. VA Vet Center personnnel assisted the survivors of the Coalinga earthquake. Clinicians with Vietanm veteran experience worked with survivors of the flood at Buffalo Creek, and the Beverly Hills nightclub fire in Covington, Kentucky. Through the efforts of Vietnam veteran trained counselors in North Carolina, mental health professionals were assisted in responding to the college student victims of an explosion in 1983. Those same professionals working again with experts first trained with PTSD in veterans consulted in the response to last weeks'tornados in North Carolina.

The VA has the largest group of people undergoing the stress recovery process. Disaster and crisis response teams are only beginning to understand the PTSD related problems of survivors of fires, floods, assualts and accidents. The VA has the opportunity to assume a leadership role in the assessment, research, treatment and understanding of PTSD and the response to catastrophic stress not only in veterans but in the whole field of PTSD. Development and enhancement of the PTSD response capability of the VA has important implications and possibilities for nation at large. And support for a National Center for PTSD in the VA would generate benefits beyond the agency itself. The prospects for the promotion of excellence within the VA would seem greatly enhanced by such a Center. Excellence in physical rehabilitation after combat injury could be matched by leadership in the single mental health area uniquely service related, PTSD. A preliminary model for such a Center has been developed.

Problem: Mandating the creation of such a Center for PTSD without the appropriation of realistic funding for such an effort places the VA in the role of having to multiply its loaves and fishes. Existing PTSD efforts have come from the reallocation of shrinking hospital resources from other programs. Existing PTSD programs are sorely understaffed and underfunded. Allocation of resources to a national PTSD Center without more adequately supporting existing treatment efforts would undermine those programs and the committments they represent. Congressional funding of the Vet Center program has spawned the allocation of other VA resources to PTSD projects. It also stimulated the direction of state, local and other federal funds such as those of the Department of Labor to this problem. Such an appropriation for a PTSD program consisting of a national Center, regional centers and enhanced specialized treatment units would be a concrete signal that the Congress this as a priority for the VA and the country. Even in a difficult year for federal spending, underfunding of this effort would be the wrong signal. At a time when global tensions have created new generations of American veterans of hostilities, and thousands of veterans with war related stress problems wait months for openings in less than 300 VA PTSD beds, the message to our sons and daughters contemplating service should be the concern and respect indicated by the funding of the Vet Centers and the Vietnam Veteran Leadership Program rather than a token mandate.

Recommendation: the Committee consider a supplemental appropriation for a National Center for PTSD,regional treatment and training centers and enhanced specialized PTSD treatment units addressing the multiple PTSD needs of the VA Medical Centers.

OFFICE OF ASSOCIATE DIRECTOR FOR PTSD

There is no question that there is a need for coordination and planning as well as opportunity for Central Office initiative in the issue of PTSD. Therefore I endorse the intent of the legislation advocating the creation of such an Office. As an outsider to VA Central Office, it seemed to me that the creation of a seperate Readjustment Counseling Service apart from the Mental Health and Behavioral Science Service was initiated within the VA to address certain concerns and maximize effective management and control. I find myself in the position of wishing to support those efforts of the VA which enhance the effective assessment and treatment of PTSD and to leave to the Administrator the details of what can best effect that effort in Central Office at any single point in time. Consequently I have no specific comment on this issue.

DRAFT PROPOSAL
FOR A
REGIONAL
COMPREHENSIVE CENTER FOR THE STUDY & TREATMENT
OF POST TRAUMATIC STRESS

VETERANS ADMINISTRATION MEDICAL CENTER
CLEVELAND,OHIO

1. INTRODUCTION

This proposal describes the organization and resources required for a comprehensive center for the study and treatment of Post Traumatic Stress Disorder (PTSD). Sincre relatively little is known about the diagnosis and treatment of PTSD this Center is designed to advance knowledge about of PTSD as well as serve as an educational site. This proposal recognizes that PTSD is not confined to Vietnam Veterans alone; female veterans, combat veterans of other eras and in particular POWs are also affected. It also acknowledges that the impact of PTSD is not confined to specialized PTSD units but affects the entire Medical Center and the community at large. Innovative approaches included in this proposal are (1) the integration of a variety of effective therapeutic strategies, (2) greater involvement of the vet centers with the medical center, and (3) provision for the development of training, evaluation and research for the Medical Center and Region.

2. GOALS AND OBJECTIVES

To develop a comprehensive regional center for the study and treatment of post traumatic stress.

To study the relative efficacy of existing and innovative treatments.

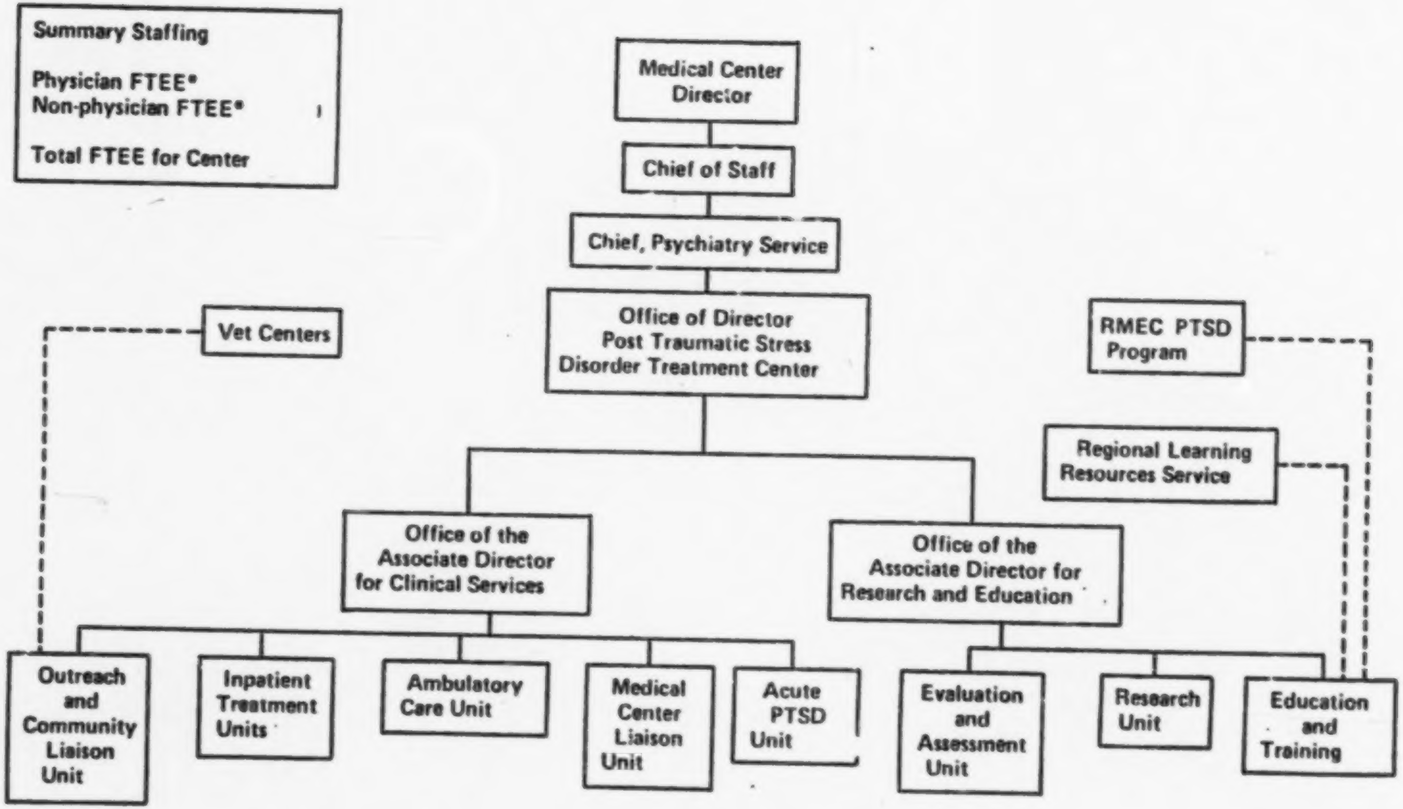
To develop a working partnership with existing community resources, particulary the Vet Centers, to provide additional vocational, social and readjustment services to patients with PTSD.

To provide both consultation and treatment for the Medical Center and Region on assessment and treatment of stress disorders.

To facilitate research in acute and chronic reactions to stress.

To develop an educational program in the assessment and treatment of PTSD as a resource for the training of staff thoughout the Department of Medicine and Surgery.

To develop an ambulatory care program (1) to provide continuing care and (2) for patients who need treatment but who do not require hospitalization.


Summary Staffing
Physician FTEE*
Non-physician FTEE*
Total FTEE for Center
Medical Center Director
Chief of Staff
Chief, Psychiatry Service
Office of Director Post Traumatic Stress Disorder Treatment Center
Vet Centers
RMEC PTSD Program
Regional Learning Resources Service
Office of the Associate Director for Clinical Services
Office of the Associate Director for Research and Education
Outreach and Community Liaison Unit
Inpatient Treatment Units
Ambulatory Care Unit
Medical Center Liaison Unit
Acute PTSD Unit
Evaluation and Assessment Unit
Research Unit
Education and Training

3. ORGANIZATION OF THE CENTER

The overall orzanization of the Center is presented graphically in the enclosed organization charts. Summary narrative descriptions of each unit and program within the center follow below.

OFFICE OF ASSOCIATE DIRECTOR FOR CLINICAL SERVICES.

Outreach and Community Liaison Unit:
The personnel assigned to the unit will coordinate existing community resources, assist in the development of complementary veteran vocational and readjustment services, and provide direct crisis intervention services to veterans in the community in consultation with community and public safety agencies. The unit will provide a direct link with local Vet Centers and provide liaison with other Vet Centers throughout the region. Staff in this unit will serve as an initial contact point in order to facilitate entry into the program and develop follow up options for veterans returning to home communities throughout the region.

Inpatient Treatment Units:
(a) Vietnam Veteran Treatment Unit
This inpatient unit is a structured treatment program for the assessment, stabilization and initial resolution of stress disorders as well as an orientation to community reentry. This unit contains a concentration of readjustment counselors since it will be a 24 hour/ 7 day a week therapeutic program - to insure clinical staff on hand whenever needed and to obviate difficulties encountered by other inpatient units. This unit also provides beds for immediate crisis readmissions.

Target population: Vietnam veterans with PTSD problems without major psychiatric disorder or substance abuse problems which would impair ability to benefit from the structured residential treatment program.

(b) Specialized PTSD Treatment Unit
This inpatient treatment unit will consist of a structured treatment program which utilizes treatment protocols targeted at specific symptom clusters (for example, intensive sleep distrubances, intrusive thoughts and flashbacks, impulse control problems).
This unit will provide important data about the variability of PTSD inpatients with different backgrounds and with different stressors. Individualized treatment and the development of specialized treatment protocols will be a primary goal of this program.

Target population: Veterans of any era who meet the critiera for any ongoing specialized treatment protocol. WW II, Korean veterans, POWs from several eras as well as male and female Vietnam veterans will be sought for this unit.

Ambulatory Care Unit:
This unit provides followup for patients discharged from the inpatient units who live within commuting distance of the medical center or satellite units at the local vet centers and the Canton outpatient clinic. The unit will also provide a cost efficient treatment option for patients whose clinical condition does not necessitate inpatient care. The objective of direct admissions to ambulatory care

is to maintain optimal function and community integration and ensure community stability while providing appropriate treatment for serious PTSD. This unit will offer outpatient treatment of graduated intensities ranging from 5 days a week to once a week. Thus, the level of services provided to a patient will be determined by the patient's clinical needs. Ambulatory services will include individual, group, marital and somatic therapies in combination with individually tailored vocational and readjustment services. Additional Vet Center space and augmented clinical and clerical Vet Center staff will be required to accomodate the increased patient load.

Target population: PTSD patients whose difficulties are too serious for Vet Center care but whose community and functional stability permit care on an outpatient basis.

Medical Center Liaison Unit:
There are numerous patients whose clinical condition necessitates treatment on another clinical service in the Medical Center. This unit will provide ongoing consultation and liaison services to insure appropriate treatment of PTSD problems on medical units as well as to insure the continuity of care among services.

(a) Psychiatry/PTSD Liaison Program
Professional staff with dual expertise in PTSD and acute psychiatry will provide consultation and limited treatment services to psychiatric treatment personnel on the assessment and treatment of patients with PTSD superimposed on a major psychiatric disorder who because of the severity of the other disorder cannot presently be treated with the PTSD Center. They will also screen patients on psychiatric units for potential admission to the PTSD center.

Target Populations: Patients with other psychiatric diagnoses (e.g. schizophrenia or major affective disorder) for whom other programs within the PTSD center are not presently appropriate but who have contributing PTSD-based problems. Veterans of any era would be served.

(b) Substance Abuse - PTSD Liaison Program
Professional staff with dual expertise in PTSD and substance abuse will provide consultation and limited treatment services to drug and alcohol treatment units. This program will train staff, provide assessment and screening and serve as consultants in the treatment and case management of patients. While assisting in assessment and treatment on the substance abuse units, the liaison staff would facilitate the transition to a PTSD unit when appropriate.

Target population: Patients with a clear PTSD diagnosis whose substance abuse problems currently preclude admission to a PTSD center unit.

(c) Medical-PTSD Liaison Program:
Professional staff with dual expertise in medical-surgical consultation and PTSD will provide consultation and limited treatment services to medical and surgical wards. By consulting and providing secondary case management and treatment services, screening and assessment for patients with medical problems who present PTSD symptoms, the program will ensure that all services in the hospital have adequate access to expertise in the management of PTSD-related problems.

Target Population: Patients with a variety of medical problems being treated on medical-surgical wards who manifest PTSD related problems.

Acute PTSD Unit:
Professional staff on this unit will provide post traumatic stress treatment to a veteran and civilian population with acute stress related problems. Understanding of acute post traumatic stress reactions is central to understanding the stress recovery process in general. If the VA is to assume a leadership role in the PTSD area where veterans make up the largest population, this capacity is essential. Services will be largely ambulatory in this unit. If inpatient treatment is required, a contract to share resources with University Hosptials and Cleveland Metropolitan General Hospital would allow inpatient treatment of civilian PTSD patients at the VAMC in return for either comparable inpatient services rendered by non VA hospitals for veterans or other needed hospital services (e.g. NMR scans for veterans). Research and training in the acute stress process will take place in the University and Cleveland Metropolitan General Hospitals. The transformation from victim to survivor is the goal of this unit.

Target Population: Veteran and civilian victims of accidents, fires, assault, childhood parental loss, rape, incest, terminal illness and other significant recent stressors will be treated.

OFFICE OF ASSOCIATE DIRECTOR FOR RESEARCH, EVALUATION AND TRAINING

The personnel requirements for the two research and evaluation components are contingent on the use of automated data entry and data processing equipment (microcomputers and access to facility ADP equipment).

Evaluation and Assessment Unit:
This unit will conduct a thorough initial assessment on each patient entering any unit of the PTSD Center. This assessment will include extensive demographic information, family, military, vocational, social, treatment and medical histories as well as a standardized comprehensive PTSD and psychological testing battery designed for the unit. Professional staff of the unit will then recommend an individualized treatment plan and assignment to the appropriate treatment component. Data collection staff will conduct periodic continuing data collection on symptoms, functioning, resource utilization, comparative treatment efficacy and clinical course. The research and analysis staff will provide periodic and timely reports, and publications documenting and evaluating the results of these data. This unit could serve as a center for collection of evaluation, assessment and outcome data from other PTSD programs.

Research Unit:
This basic research unit will provide core seed staff to stimulate basic research in acute and chronic stress disorders, their natural history, etiology, and physiological and social features as well as innovative and experimental treatments. The unit will also serve as a focus and support for cooperative studies in basic and clinical PTSD research.

Education and Training Unit:
The staff of this education and training unit will develop and coordinate an ongoing continuing education and training program for the Center staff.

(a) PTSD Clinical Training Program: The staff of this program will develop and coordinate a fellowship and mini-residency program for professional training in PTSD in conjunction with other existing PTSD programs and the Readjustment

Counseling Service.

(b) Training and Education Program: The program serves a liaison with the RMEC based PTSD Training and Education Program for PTSD. The RMEC PTSD training and education program will develop and implement, with professional staff and experts from throughout the VA and civilian sectors a program of consultation, education and training for all clinical and administrative services in treatment, research and program development for PTSD. Existing PTSD treatment programs and the Readjustment Counseling Service and the Vet Centers and their personnel will provide additional expertise for this effort.

(c) Mid Atlantic RMEC Education and Training Program: This program will plan, develop, implement and evaluate PTSD educational services for the VA nationally. Education and Training programs consist of the following major components: assessment and collaboration of regional centers; assessment and collaboration of existing inpatient PTSD programs; short and long term mini residencies; PTSD conferences; development of prototype for inservice unit level training.

Appendix B

Duke University
DURHAM
NORTH CAROLINA

DEPARTMENT OF PSYCHOLOGY

POSTAL CODE 27706
TELEPHONE [illegible]

To: Phillip White, M.D., Director, VAMC Cleveland
From: John Russell Smith
Date 24 February 1984
Subject: CENTER FOR TRAUMA RECOVERY

The timing is right for comprehensive treatment programs in Post Traumatic Stress. Such programs could place the VA in world leadership in this field. Post Traumatic Stress is the single medical issue outside physical rehabilitation or prosthetics which is clearly the domain of the VA. The problem is directly service related. Veterans form the largest population of those with PTSD. Such a CENTER FOR TRAUMA RECOVERY could accomplish the following goals:

1. Create the 1st comprehensive PTSD treatment program.
   Integrate targeted inpatient/outpatient services
   Consolidate related treatment services
   Shorten inpatient time
   Enhance treatment success rate
2. Integrate all recent treatment advances.
   Physiological, behavioral, pharmacological innovations by Horowitz, Keane at Jackson, Kolb at Albany, Penk at Dallas could be incorporated.
3. Integrate Vet Centers and medical centers.
   Provide 1st model for RCS and VAMC integration.
4. Create 1st program for all PTSD veterans.
   Women, Vietnam, Korean, WW II veterans included.
5. Provide 1st hard research data on treatment.
   Differential assessment, treatment outcome and limits.
   Data to settle PTSD or no questions, multiple diagnoses.

6. Launch VA into general PTSD leadership. Integrate VA, Case Western, county hospitals in programs for civilians, police, firemen, rescue workers, medical trauma victims, rape, bereavement, disaster, assault and burn victims. Associations already in place.
7. Provide data for discrimination of minority of compensable PTSD cases from majority of recoverable ones.
8. Create training and residency programs in PTSD. Coordinated with Case Western and RMEC
9. Reverse recent adverse VA publicity on PTSD. Structure, design and staffing obviate problems of other units.

UNIQUE ASPECTS OF THE CENTER FOR TRAUMA RECOVERY

A. Top Staff - best clinicians and researchers in and out of VA on board or actively considering affiliation.

B. Full Hospital Support- Cleveland VAMC unique in degree of commitment and support.

C. Vet Center and Hospital Integration- coordination mechanisms already established. Exist nowhere else in this form.

D. Full Time Coverage- 24 hr/7 day coverage by clinicians places resources on hand whenever needed. Crisis service. Immediate rehospitalization eased. Close coordination with community emergency services and public safety.

CENTER FOR TRAUMA RECOVERY
Page Three

E. Client Responsibility- Prime emphasis on client responsibility for actions and consequences. Staff and client focus on enhancing control over alcohol,drugs, weapons,and destructive behavior in multiple daily examinations of acts.

F. Broad Clientele. - Women, Vietnam, Korea, WWII clients

G. Extensive Community Involvement- Client involved in supervised commuity enhancement projects. Extensive veteran organization, community agency and successful peer role model support network developed for maximum impact.

H. General Post Trauma Program- Case Western and affiliated hospital program for other survivors.

I. Built in assessment and outcome research.

J. In house residency and training program with RMEC and Case Western

K. International Advisory Board- leading world experts on PTSD have agreed to ongoing consultation to program.

L. Buddy system- program and vet center graduates encouraged and expected after screening and training to serve as 24 hour on call buddies for crisis, support and accompaniment on difficut matters.

Mr. Principi. I have one question. Mr. Smith, what would you recommend that the VA do to increase coordination and sharing of knowledge between Vet Center personnel and inpatient personnel who deal with PTSD?

Mr. Smith. I think there has to be some type of coordination at the central office level of those kinds of efforts between existing post-traumatic-stress programs and there also has to be some kind of research effort going to demonstrate the effectiveness of various kinds of treatment modalities. For example, as we look at issues of cardiology, coronary care, and geriatric care, it has not been that we have waited until the final answer appears. It is rather, as in the case of AID's, that we have seen a problem, allocated resources and come up with some answers in a relatively short period of time.

We need dollars allocated for regional centers or national centers for post-traumatic stress. We also need some kind of centralized coordinating body at the central office level that coordinates the Vet Center Program, PTSD inpatient programs and research and education efforts that spread the knowledge that is gained throughout the system.

Mr. Principi. I have heard it said, I believe the VA has stated because PTSD is new to the list of mental health facilities classified by the American Psychiatric Association for the first time in 1980 that there is disagreement among health-care professionals regarding its proper diagnosis and treatment and that it would be premature to establish guidelines to establish any specific policies or directives to aid the various medical centers as they provide treatment for veterans with this disorder. Do you agree with that?

Mr. SMITH. I think there are two issues. One is that there is now in 1984 far less disagreement among professionals involved in the actual treatment and diagnosis of post-traumatic-stress disorder on what are appropriate and effective treatments than there was several years ago.

The primary areas of disagreement come from people who would rather wait and see if this problem will simply go away if we ignore it and those people who have regarded it for a long time as simply a manifestation of a character disorder and not a legitimate diagnosis. So, while there are areas of disagreement, they are not so great as differences for example, among, physiological researchers and there is much less now than a couple of years ago.

Second, it has never been the case that the way we respond to a new diagnosis is to say, "well, let's set it aside and wait and see if it goes away." For example, in the case of AID's or in the case of cancer, we have said if there are differences, what is the scientific approach? We approach with rigor and scientific inquiry, we allocate research dollars and we say let's do some treatment evaluation studies, rather than saying that that is a reason for us not to move. There is generally a reason for us to take action, especially when we have a long waiting list of people who need help and are asking for those services.

We certainly see this in the case of readjustment counseling service. We started out with an interim program and we have seen the need and the demand for services expanding. We are in the infancy in terms of post-traumatic-stress disorder treatment programs and now is not the time to say, "well, let's not do anything about it," simply because we do not have the final answer. We get the final answer by funding different kinds of treatment alternatives and then doing hardnose evaluation of outcomes and effectiveness.

Mr. PRINCIPI. Thank you, Mr. Smith. There may be additional questions which the members wish to ask and we would request that you respond for the record. I regret that the chairman had to leave, but he will read your testimony.

Mr. SMITH. Thank you.

[The response of John R. Smith, M.A., Clinical Program Director Appointee, Center for Trauma Recovery, Brecksville Division, VA Medical Center, Cleveland, OH, to written questions submitted by Hon. Alan K. Simpson, Chairman of the Senate Committee on Veterans' Affairs, follows:]

RESPONSE OF JOHN R. SMITH, M.A., CLINICAL PROGRAM DIRECTOR APPOINTEE, CENTER FOR TRAUMA RECOVERY, BRECKSVILLE DIVISION, VA MEDICAL CENTER, CLEVELAND, OH, TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. What do you see as the role--now and in the future--of the VA regarding treatment, research, and training concerning PTSD?

Answer 1.

Role of VA

Emerging research and clinical evidence indicates that the VA has the largest identified populations of patients with Post traumatic stress problems. These populations include not only veterans of Vietnam, but those of Korea, World War II and post Vietnam. They include POWs of several eras, many of whom have been identified through the POW reexamination program. Clinical work on medical units with non war-related injuries is increasingly recognized as involving the same traumatic stress process. For example, VA consultation psychologists work with motorcycle accident victims with stress reactions on spinal cord injury wards. Mental health professionals working on oncology wards with dying patients have begun to recognize the similarity of problems to stress reactions.

Therefore, the VA in fullfilling its mandate to serve veterans, has the opportunity to assume a pre-eminent role in PTSD work. Whether it be the development and evaluation of treatment modalities, the spurring of clinical and basic research, or the dissemination of training and expertise in the field of PTSD, the work has been begun in the VA and needs to be enhanced and consolidated. By collaborating with and encouraging the work of PTSD clinicians, evaluators and researchers in the VA and promoting close collaboration with extra VA PTSD experts, the VA has a unique opportunity to not only address the premier service related mental health problem but to lead the nation in resolution of a growing clinical problem. While others may assist in the solution of acute PTSD problems, the VA has an indispensable role in the investigation and treatment of delayed and chronic stress reactions.

Question 2. The VA has conducted a number of Regional Medical Education Centers on Post-Traumatic-Stress Disorder. In your opinion, are these Regional Medical Education Programs the most effective means of training VA health-care professionals about the diagnosis and treatment of PTSD and if not, what other means would you suggest as more effective for this purpose?

Answer 2.

PTSD Training

The RMEC (Regional Medical Education Center) training programs on PTSD have made an fine start as a means of enhancing the expertise of VA health care professionals about PTSD. While some VA health professionals remain skeptical of PTSD and Vietnam veteran patients, most VA health professionals are already interested and concerned about this problem. The major problem is that their concerns and needs outstrip our current ability to address them seriously. Our medical centers already treat large numbers of PTSD patients. But diagnostic questions still taxing the experts on the cutting edge confront these clinicians every day. The anger, confrontation and active behavior so frequently characteristic of PTSD patients in a hospital setting present management and treatment issues we have only minimally addressed in our trainings to date. Our training task is then to address seriously these problems and concerns. We must develop an approach that respects the expertise and current knowledge of our professional staff and yet invites and promotes growth and rethinking of some assumptions or solutions to PTSD problems.

To date the RMEC trainings have provided an good overview of the significant issues. However the seriousness with which those attending come to the problems, and their day to day issues in treatment and diagnosis cannot be adequately addressed in such a forum alone. Amplified training might take place on several levels, some of which are already underway.

1. Training Materials- Training films, video tapes and printed materials focused in depth on such pressing questions as diagnosis, multiple diagnoses, ward structures, management of PTSD behavior, and multiple treatment approaches are badly needed. A excellent training film on diagnosis is well underway at the ST. Louis VAMC. Other excellent written case presentations with individual tasks for trainees have been prepared at various clinics and hosptials. Efforts to consolidate, update, evaluate, refine and distribute them could be expanded.

2. Hands on training- More immediately useful training at this stage might come from intensive hands-on collaborative training efforts. This might involve a 2-3 day observation, participation and collaboration on actual selected training cases. Diagnostic training might involve participant interviewing, testing and discussion in small groups under the supervision of PTSD diagnostic experts. For treatment training, actual rap group , individual, crisis, desensitization and family sessions run, observed and discussed by trainees over 2-3 days under the supervision of leading experts has been enormously successful as at a recent Vet Center training in Dallas.

3. PTSD Unit Site Training- Some of the best training will result from the training of clinicians who are detached to work for blocks of time at PTSD units, Vet Centers or hopitals in formal collaboration with a PTSD team. The ideal result of these 2 week to 3 month residencies would be the dispersal of thoroughly trained PTSD clinicians at the various medical centers and clinics who can then collaborate with their colleagues at each station. Such a program might be made available at several centers with opportunities for nurses, psychologists, physicians, readjustment specialists, and vocational rehabilitation specialists.

4. PTSD Conferences- Further enhancing the process would be the instigation of regular conferences of leading critics, clinicians and researchers in PTSD from within and without the VA to foster the rigorous dialogue and critique that will address concerns and problems as well as boost innovative and effective advances. The MacArthur Foundation has been implementing such network conferences and collaborations on various mental health issues with considerable recent success.

5. FRANK DISCUSSION - At a few training we have invited former VA Hospital and Vet Center clients who had severe PTSD problems, to discuss their attitudes, reactions to staff and process of chance with the VA professionals at the conferences. These frank exchanges between clients and staff in a neutral setting with small groups has proved to be enlightening and rewarding to both sides. The same effect has been achieved by discussions between pro-PTSD and skeptical staff over treatment and diagnostic issues.

Question 3. How would you recommend that a National Center for PTSD disseminate its knowledge of PTSD diagnosis and treatment to the individual VA medical centers, especially to those which do not have inpatient PTSD units?

Answer 3.

National Center

Considerable discretion might best be exercised in the creation of a national center. As one of the prime advocates of such a Center for several years, I would currently urge a step wise approach to building such a Center. Initially such a Center might be more of a collective collaboration among several Centers and experts as outlined in point #4 of Q.2 above. It might be composed of several discrete components which have regular and frequent contact and interaction. Within such a Center, whether centralized or not, there should be a diversity of techniques and options being evaluated representing all the major streams of thought on PTSD. The healthy ferment created by such an arrangement could best produce the rigorous dialogue which promotes excellence.

A prime reason for such an approach is to avoid communicating the covert message to the VA mental health system that only an elite group of experts have the corner on knowledge about PTSD. The numbers of patients currently in treatment, and the overwhelming demand for such services demand that the existing expertise of VA professional be enhanced and not demeaned by the creation of PTSD centers.

Given such an arrangment, the Center would function best by :

1. Establishing a residency program which enabled researchers and clinicians from various medical centers to come for concentrated periods of time for training and collaborative work.

2. Dispatching trained staff from the center or other PTSD experts to medical centers or clinics to work for concentrated periods of time with health professionals there in diagnosis, case consultation, and treatment.

3. Participation and organization of regular expert conferences, more intensive 2-3-4 day workshops with hands-on involvement in particular interventions, diagnosis or research.

4. Providing a site and staff for the development and evaluation of innovative unit structures, treatments and collaborations that might create models for future programs.

5. Developing assessment and evaluation techniques for diverse PTSD patient populations and treatments.

6. Developing consultation models for PTSD within VA Medical Centers.

7. Promoting and conducting clinical research and cooperative studies n PTSD, diagnostic overlap, treatment evaluation and normal stress response.

Question 4. In your view, where does PTSD treatment and research currently fall as far as other VA priorities are concerned?

Answer 4.

Priority of VA PTSD Research

The Administrator's Advisory Committee on The Readjustment of Vietnam Veterans, on which I serve as Chairman, has had a continuing dialogue with the VA research office on this subject. As you are aware, the question of PTSD has always been controversial. The inclusion of PTSD in the latest diagnostic manual of the American Psychiatric Association has precipitaed precisely the type of ferment and discussion in the professional community which those of us who worked on the entry wanted in order to advance the scientific inquiry and promote examination of treatment. That ferment over PTSD as noted in a series of papers being presented this month at the American Psychological Association meetings reflects both the professional concerns and the personal biases long associated with the discussion of war reactions.

As discussions and questions about PTSD has become more of an issue, requests for funds for research to address those questions have increased. These requests have, as noted by Dr. Hollis Boren, Chief of the VA Research Office, in his discussions with the Advisory Committee last fall, have conflicted with existing research priorities aimed at the recruitment and retention of basic science researchers. In addition, a closer focus on the dialogue over PTSD, treatment and its relation to other psychiatric problems has more sharply defined some of the glaring questions, difficulties and unsupported assumptions in the scientific community in general, and in the VA review committees and the VA Research Office in particular. More rigorous attention to emerging design and diagnostic questions is being demanded of PTSD researchers.

As might be expected in a burgeoning new field, PTSD researchers and clinicians are demanding a greater level of sophistication and expertise in PTSD on the review committees. This healthy debate has precipitated fruitful discussions. These dialogues are leading to more rigorous and detailed research proposals to the Research Office. The dialogue is also promoting a reexamination of the review committees and the priority of PTSD in funding VA research. The forthcoming October VA research conference on PTSD in Nashville is a concrete example of this increased attention on the part of the VA Research Office. The review and reexamination of the Peer Review Committee expertise on PTSD is a further example. In response the Advisory Committee is awaiting the outcome of these initiatives.

With regard to treatment, there is an increased attention to PTSD and related problems. Encouragement attention to PTSD treatment has increased at Central Office level.

However, the basic problems stem from conflicting messages received at local medical centers. PTSD units, the Readjustment Counseling Service and sympahetic professionals encourage further attention to our priority of PTSD units and programs. Other professionals and demanding PTSD patients on admissions and acute treatment wards, encounter a degree of obstreperousness, in patients diagnostic uncertainty and reaction in staff members that fuels a different view. This view focuses on the anti-social aspects of patient behavior and their frequent lack of coorperation with staff. Recognition in the face ofinability to treat these patients as successfully as the staff might like, fear and anger fueled by difficulties managing patient behavior foster a frequent impulse to dismiss or be rid of them.

Therefore, efforts to enhance the priority of PTSD treatment often serve to heighten resistance and negative reaction. Only when a dialogue is promoted, and serious and widespread efforts at educations bring changes and insights to the daily problems of these staffs can the priority of PTSD be truely augmented.

Question 5. What broad guidance can be issued to the field which would enable the individual medical centers to continue to develop their own treatment programs for PTSD and yet ensure that care is coordinated and knowledge is disseminated among Districts or Regions nationwide?

Answer 5.

VA Guidance on PTSD

Broad guidance is already taking place on the question of PTSD in the VA. Actions by the Congress in establishing and extending the Vet Center program, encouraging the National Needs Assessment Study undertaken by the VA, and proposed support for PTSD inpatient initiatives have demonstrated that Congress has considerable investment in this issue. Support by the Department of Medicine and Surgery (DM&S) has increased for those medical centers which have allocated their own resources to establish PTSD programs. RMEC PTSD training conferences and film development is also notably enhanced. All of these efforts are having profound reverberations in the system by demonstrating the priority of PTSD. The forthcoming research meeting and planned enhancement of PTSD expertise in the research review committees adds significantly to this broad guidance.

The more immediate problem is what to do to enhance the growth of knowledge and effective PTSD treatment. The answers reflect how one views the problems.

From my observation and perspective, PTSD clients often present a troublesome problem to our medical centers. Apart from the core symptoms of intrusive thoughts and imagery, the prime manifestation of PTSD in these patients is the reservoir of unresolved feelings so frequently galvanized as bitterness, frustration and anger. In some patients it is turned inward, as depression, self-destructive behavior or suicidal impulses. In others, it is projected outward in anger and rage, intolerance and irritability. Armed with these emotions, and energized by their general lack of psychosis, these patients often display a high level of activity that presents significant management problems to the hospital staffs. Responses in clinicians and professional staff include concern, compassion, fear, confusion, anger, tolerance, resentment, overidentification, and bafflement and therapeutic understanding. From a PTSD prospective, VA professional staff can be broadly characterized with respect to PTSD as falling into three classes - those knowledgeable and effective with PTSD, those interested and concerned but having reservations , reluctance or inexperience with effective PTSD treatment and patient management, and those somewhat skeptical, burned-out, or hostile to PTSD and PTSD patients.

In some respects, the establishment of the Vet Center program and the Readjustment Counseling Service was an attempt to circumvent these patient and staff problems by directly establishing readjustment services. The success of the Vet Centers is a tribute to that approach to counseling. However, this approach has subordinated the dialogue within the medical centers to an important but secondary role. One consequence in many quarters is a resentment over the lingering feeling that PTSD counselors and experts are viewed as the sole people knowledgeable about and effective with PTSD, with the unspoken implication that the hospital staffs are less competent.

No matter how well or how effective an individual PTSD unit or ward at medical center is, the waiting lists and numbers of patients with PTSD related problems scattered throughout the hospitals attest to the improbability of any specialized staff to deal with all the PTSD patients in a medical center. Therefore it is imperative that we now move to enlist and ally ourselves with the professional staffs of the medical centers. We must acknowledge their expertise, their questions, and their problems. We can move to enlist them as colleagues empowered to surmount the problems and creatively meet the needs of the patients with multiple problems they are seeing independently of the formal PTSD programs.

My response then is to suggest that we now face an important choice as we decide how best to enhance knowledge treatment and understanding of PTSD in the system. We can continue to circumvent the problems as before or we can use the experience of the recent past to now promote creative solutions within the existing systems.

Therefore rather than suggest how the guidance should be implemented, I would prefer to be mandated to respond both to the patients and to the medical centers needs. Then I can be held accountable for results rather than instructed as to methods.

Mr. PRINCIPI. Dr. Martin Cohen and Sharron Dreyer. We welcome you. You may proceed.

TESTIMONY OF A PANEL CONSISTING OF MARTIN H. COHEN, M.D., CHIEF, ONCOLOGY SECTION, VETERANS' ADMINISTRATION MEDICAL CENTER, WASHINGTON, DC; AND SHARRON DREYER, B.S.N., ASSISTANT ADMINISTRATOR, PATIENT CARE SERVICES, HOSPICE OF NORTHERN VIRGINIA, INC., ARLINGTON, VA

Dr. COHEN. The goals of terminal care are to reduce or eliminate human suffering while allowing dying to occur. Suffering always accompanies a terminal illness. It results whenever the physical, emotional, social, and spiritual being that constitute a person is disrupted. Thus, overwhelming pain causes suffering. Knowing that one will never again be well causes suffering. Loss of hope is a major cause of suffering. The terminally ill patient is dying against his will. He will die before those he loves. The awareness of his aloneness and separateness, of his helplessness against the ravages of disease often cause almost unbearable suffering.

Society has recognized the needs of the terminally ill. It has initiated programs to meet these needs. While these programs may, with greater or lesser success, ameliorate patient suffering, more basic questions are still unanswered. As far as I am concerned, we still do not know the optimal way to control pain or other distressful symptoms to improve a patient's functional status and mobility, to improve the quality of a patient's social interactions, to increase life-satisfaction or to relieve feelings of isolation and helplessness. We do not know the psychological consequences of telling a patient that there is no more treatment available for him and that from now on we will only provide for his comfort. We do not know how best to manage the bereavement response of families after a patient's death. Further, we also do not know how to prevent burnout of the staff providing care for terminally ill patients.

I submit that answers to the above questions could greatly improve the format of the terminal care. I further strongly believe, for many reasons which are stated in my complete testimony, that Veterans' Administration medical centers are ideal places to conduct this research. I stress a research orientation to terminal care, because I firmly believe that research protocols constitute the best available treatment for the condition under study. Research studies are emotionally rewarding to both staff and patients because beneficial results are often clearly demonstrated. A strongly positive patient-staff interaction results which motivates both groups to maintain hope and to continue to seek even further improvements.

I would like to illustrate these points by describing some of the studies being conducted at the Washington, DC VA Medical Center that relate to the care of the terminally ill cancer patient. The most important problem that these patients face is pain control. We theorized that pain control could be best achieved by continuously infusing morphine so as to maintain a constant drug level in the bloodstream. We tried this in patients who had persistent pain despite large doses of potent narcotics taken by mouth and found that we could achieve complete pain relief by our method. Moreover, patients remained alert and ambulatory. Many of these patients were subsequently able to go back to their oral medication and be maintained in a pain-free state. This treatment was also highly effective in relieving severe shortness of breath, a frightening symptom for both the patient and family. This treatment is now available for large numbers of patients, both inside and outside of hospitals because we and others found safe and easy to use methods for prolonged venous access and because commercial companies have developed appropriate constant rate infusion pumps.

A second major effort of ours concerns relief of patient psychologic distress. We hypothesize that dying does not have to be a negative experience. Many patients find solace in their terminal months and have related to us that this time has been very important and even satisfying. A nurse on our unit therefore devised a research study to investigate the effects of therapeutic use of self. In this study nurses will establish a therapeutic alliance with the patient that will be maintained until death. As part of the therapeutic relationship nurses will use guided imagery, therapeutic touch and relaxation exercises as aids to discover causes of suffering and to externalize these causes.

Florence Nightingale once said "What the nurse has to do is put the patient in the best condition for nature to act upon him." That is the goal of this study. If beneficial results are obtained, we envision that paramedical personnel could easily be trained in these techniques.

Finally, I would like to consider the question of burnout in terminal care staff. Out of 25 nurses who started work on our cancer ward 10 to 15 years ago, at least 7 still continue to work only with cancer patients. I think that a major reason for these nurses' continued job satisfaction is the hope that is instilled in patients and staff by finding new and better ways to solve old distressing problems. Our research orientation toward improving as much as possible the remaining life of our patient is a continuing stimulus to professional growth and a continuing source of emotional award.

In conclusion, there are numerous important unanswered questions about caring for the terminally ill, the answers to which could greatly alleviate suffering and result in improved quality of life. Such questions are best answered by carefully planned and executed research studies performed in a controlled environment. Veterans' Administration hospitals have the personnel and facilities to conduct these studies. I have presented several examples of such research as it is conducted on our unit. I urge your continued support of such programs.

Thank you.

Mr. PRINCIPI. Thank you, doctor.

[The prepared statement of Martin H. Cohen, M.D., chief, oncology section, Veterans' Administration Medical Center, Washington, DC, follows:]

PREPARED STATEMENT OF MARTIN H. COHEN, M.D., CHIEF, ONCOLOGY SECTION, VETERANS' ADMINISTRATION MEDICAL CENTER, WASHINGTON, D.C.

Terminal Care: The Veterans Administration's Unique Opportunity to Do it Better

The goals of terminal care are to reduce or eliminate human suffering while allowing dying to occur. Suffering always accompanies a terminal illness. It results, according to Eric Cassel, whenever the physical, emotional, social and spiritual being that constitute a person is disrupted. Thus, overwhelming pain causes suffering. Knowing that one will never again be well causes suffering. Disruption of normal body functions causes suffering as does inability to participate in usual everyday activities. Loss of hope is a major cause of suffering. The patient is dying against his will. He will die before those he loves; the awareness of his aloneness and separateness, of his helplessness against the ravages of disease often cause almost unbearable suffering.

Society has recognized the needs of the terminally ill. It has developed programs to meet these needs using acute care hospitals, nursing homes, community health agencies and, most recently, hospices. While these programs may, with greater or lesser success, ameliorate patient suffering more basic questions are still unanswered. As far as I am concerned we still don't know the optimal way to control pain, to relieve the myriad of distressful symptoms that terminal patients suffer, to improve a patient's functional status and mobility, to improve the quality of a patient's social interactions, to increase life-satisfaction or to relieve feelings of isolation and helplessness. We do not know the psychological consequences of telling a patient that there is no more treatment available and that from now on we will only provide for his comfort. My impression is that this is often the worst thing that can be done. Further, we do not even know how to prevent "burn-out" in the staff providing care for terminally ill patients nor have we developed ways of dealing with the conflicts that inevitably occur among physicians, nurses and other health care personnel in the management of these patients.

I submit that answers to the above questions could greatly improve the format for managing the needs of the terminally ill. I further strongly believe that Veterans Administration Medical Centers are ideal places to conduct this research. First, VA Medical Centers already employ the multidisciplinary personnel required for such an undertaking including physicians, nurses, psychologists, social workers, physical therapists, occupational therapists, speech therapists and dietitians. Second, VA outpatient services have expanded in recent years and hospital based home care is also available. Third, there are large numbers of patients in the VA system who require terminal care. Fourth, because personnel, patients, and facilities are already available, research in this important area could probably be done more cheaply in the VA than anywhere else. An operational research program would require that personnel from each of the above disciplines meet to identify specific patient needs as they relate to their specialty. Research protocols could then be developed to determine which methods are most efficacious and cost effective in meeting these needs.

I firmly believe that research protocols constitute the best available treatment for the condition under study. Research protocols are the end result of considerable thought as to 1) what is the most appropriate and important question that can be asked to improve a given condition and 2) what methods can be used to best answer this question. Research studies are emotionally rewarding to both staff and patients because beneficial results are often clearly demonstrated. A strongly positive patient-staff interaction results which motivates both groups to maintain hope and continue seeking even further improvements.

I would like to illustrate these points by describing some of the studies being conducted at the Washington, D.C. VA Medical Center that relate to the care of the terminally ill cancer patient. The most important problem that these patients face is pain control. We theorized that pain control could be best achieved by continuously infusing morphine so as to maintain a constant drug level in the blood stream. We tried this in patients who had persistent pain despite large doses of potent narcotics taken by mouth and found that we could achieve complete pain relief by our method. Moreover, patients remained alert and ambulatory throughout their days or weeks of treatment. Many of these patients could then go back to their oral medication and be maintained in a pain-free state. This treatment was also found to be highly effective in relieving severe shortness of breath, a frightening symptom for both the patient and for any family member watching the patient struggle to breathe. I consider these results to be a significant advance. To make such treatment available for large numbers of patients, both within and outside of hospitals, requires that a safe method of prolonged venous access be found and that small, portable, lightweight constant rate infusion pumps be developed. We and others have demonstrated the safety and efficacy of catheters inserted in large central veins. Patients and families can easily be taught to manage these catheters at home. Concurrently, several companies have developed appropriate pumps. Thus a successful treatment for a highly distressing symptom is now ready for widespread use.

A second major effort of ours concerns relief of patient psychologic distress. We hypothesize that dying does not have to be a negative experience. Many patients find solace in their terminal months and have related to us that this time has been very important and even satisfying. A nurse on our unit therefore devised a research study to investigate the effects of "Therapeutic Use of Self". In this study nurses will establish a therapeutic alliance with the patient that will be maintained until death. As part of the therapeutic relationship nurses will use guided imagery, therapeutic touch and relaxation exercises as aids to discover causes of suffering and to externalize these causes. Florence Nightengale once said "What the nurse has to do is put the patient in the best condition for Nature to act upon him." That is the goal of this study. Study results will be evaluated by objective parameters. If beneficial results are obtained we envision that it would be relatively easy to train paramedical personnel in the techniques to be used.

Finally I would like to consider the question of "burn-out" in staff who constantly deal with terminally ill patients. Out of 25 nurses who started work on our cancer unit 10-15 years ago at least 7 still continue to work only with cancer patients. Why have some nurses not burned out? I think that a major reason for continued job satisfaction is the hope that is instilled in patients and staff by finding new and better ways to solve old distressing problems. Our staff never feels that a dying terminal patient should be shunted to a back room and be given minimal support. Our research orientation toward improving, as much as possible, the remaining life of our patient is a continuing stimulus to professional growth and a continuing source of satisfaction. Patients on our ward are never considered incurable. We can always do something better for them.

In conclusion, there are numerous important unanswered questions about caring for the terminally ill, the answers to which could greatly alleviate suffering and result in improved quality of life. Such questions are best answered by carefully planned and executed research studies performed in a controlled environment. Veterans Administration hospitals have the personnel and facilities to conduct these studies and they see a patient population that would receive maximum benefit from the results. I have presented several examples of such research as it is conducted on our unit. I urge continued support for such programs.

2C North

Does emotional involvement between patients and staff preclude objectivity? Not on 2C North, where empathy has resulted in creative —even groundbreaking—nursing care.

By Anita Johnston-Early

2C North is a unit that can boast of few physical amenities. The architecture is antiquated; private and semi-private rooms and bathrooms are scarce. It is where patients come for treatment if they have cancer of the lung, prostate, liver, or stomach, or mycosis fungoides, a rare lymphoma.

Some might reject 2C North at first glance, or cringe at sharing a room with three patients. A few would find it distasteful to walk down a corridor to a bathroom. Some would have to be convinced that the treatment here is very good and not easily duplicated elsewhere.

But because of the superb care given by a caring staff, the environmental inadequacies of 2C North are hardly noticeable.

2C North restores those whose emotional reserves have been severely depleted by the shock of knowing that they have cancer. Where the earth once had been crumbling beneath, 2C North builds a firm foundation. Nurses on 2C North are not afraid to touch and hold or to speak about cancer and dying. Baths and bedmaking are often delayed as nurse and patient sit side by side assuring, listening, and sharing. Together, we ask what can be done today to make life more pleasant, what can be achieved with the resources at hand. Nurse, patient, family, and doctor rejoice together when an x-ray shows that a tumor is shrinking. And when it is painfully clear that treatment has failed and there is no where to go but into somebody's arms, those arms are waiting on 2C North.

The 2C North nursing staff is involved. They are sometimes warned that involvement might mean a lack of objectivity, but they have learned long ago that the opposite is true. Involvement is not only productive, it is also natural. Yet since it can be draining, the nurses are advised and supported by a psychiatrist, who years ago was an intern on 2C North. With him, they learn to deal with their emotions and get to the core of problems. The staff are able to pool and complement their strengths so effectively that together, they have become an imposing force.

Empathy is the unit's most valuable characteristic. Indeed, it is difficult not to learn it, for superficiality is quickly abandoned in the face of acute hurt and need. Patients and families continually teach and reinforce the concept of empathy in one another. Roger and his mother are two of many we have learned from.

Roger was an unassuming 38-year old patient who came to us from Appalachia. His cancer was so widely spread that we could hope only for a transitory remission of his disease; that's all he ever had. After a six-week hospitalization for intensive chemotherapy, Roger was discharged to return every three weeks for maintenance treatment. Within a few months his cancer, again growing, was unresponsive to new treatment. Roger was not sorrowful. He did not complain. He just accepted what was happening.

He asked that his mother be called to share his last days with

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him. She arrived carrying only a paper sack. She remained at his side, helping the nurses bathe and turn his now edematous and jaundiced body. She slept in a chair when he slept. She coaxed broth into his ulcerated mouth and gently rubbed his aching limbs. A touch, a glance, words of assurance and encouragement communicated that this was just another hardship to be endured. They had put up with plenty before, and they could get through this now. Roger wasn't to worry, "because she'd be just fine." He would smile at her confidence and then sleep again for a while.

When it was obvious that he was dying, Roger called his mother to his side and whispered his good-bye. When he died, she turned from him, seeming to accept her fate as he had, and left his room carrying her paper sack.

It was hard for those of us who had shared those days with her to say good-bye. We felt a kinship with her and she with us. Many of our patients and families spend weeks, months, and even years undergoing treatment. The bonds between us grow, regardless of how much time we have together. During holidays, many family members return to reminisce and bring gifts. Occasionally, they telephone or write as new adjustments are being made in their lives. And then one day we realize we haven't heard from one of them in a long time, and we know that for him or her, adjustment is complete.

While the greatest nursing contributions we make are in day-to-day bedside care for patients, we have made other unique and worthy contributions. One had to do with the care of the patient with mycosis fungoides (MF). MF begins with skin tumors, ulcers, or plaques that are sometimes thick and leathery. Because MF is difficult to diagnose in its early stages, patients often spend years going from doctor to doctor. At diagnosis they may be bitter, depressed, and withdrawn.

The skin lesions break down, become infected, and drain. The odor is repulsive. Often a person's entire skin surface is involved. Intravenous therapy becomes difficult to administer, and bathing and topical application of creams tedious and unpleasant. Eventually the internal organs are affected. The disease now becomes fatal.

Alice is the research nurse in charge of MF patients on 2C North. She is young and pretty, with clear, smooth skin. It is impossible not to be struck by the physical contrast between patient and nurse. But Alice seems to see past the smelling, oozing lesions. She patiently instructs each person in the use of topical chemotherapy and creams, using video tapes that she has prepared. She listens attentively as patients repeat the instructions back to her. With proficiency she gives IV therapy in veins hidden beneath hard plaques.

Alice faithfully supports her patients through the slow and difficult months of electron beam therapy that sometimes further damages the skin by reddening or burning it. She gives her patients jobs to do to help them remain productive and offers suggestions on how to make positive changes in their lives. She helps her patients develop inner resources that strengthen their personalities. Based on her experience with MF, Alice has written several papers that not only provide guidance on various aspects of the disease, but also give insight into support of cancer patients in general.

Making a difference in each patient's care is the norm on 2C North. But the nurses also have unique opportunities to do clinical research that can affect the lives of many patients. One nurse conducting studies in lung cancer noticed that a large percentage of her long-surviving patients with small-cell lung cancer had stopped smoking at or before their cancer was diagnosed. All had previously been heavy smokers. She had not been asked to record this information, but because she knew her patients so well, this phenomenon became apparent to her. She began keeping records on new patients, and after several years, her suspicions were confirmed: The patients who had stopped smoking at or before diagnosis had a better response to treatment than those who continued to smoke. These results were published in a major medical journal and widely circulated by the press.[*] The finding prompted physicians to advise their patients that smoking abstinence was an aid to treatment. It encouraged scientists to test whether smoking abstinence was associated with longer survival.

Another challenge that became a triumph concerned patients whose tumors obstruct large and small airways so that their lungs can no longer accommodate oxygen, causing these patients to smother. While these individuals were clearly suffering, the medical and nursing staff often treated symptoms inadequately because they feared that narcotics would further interfere with respiratory function. Some stood by helplessly, but other nurses prodded the medical staff into action. Finally, all physicians and nurses became convinced that they were obligated to intervene aggressively and treat pain, anxiety, and shortness of breath.

I became principal investigator to study safety on the efficacy of continuous IV morphine in the patient with intractable pain and dyspnea. We formulated a plan to deliver continuous intravenous morphine to those patients for whom all other analgesic regimens have failed.[**] Patients were monitored so that medication would not depress an already compromised respiratory system. Pain was safely relieved as were anxiety and dyspnea. Our head nurse reported the preliminary results at an Oncology Nursing Society meeting. Yes, it was possible, with careful monitoring and titration of medication, to significantly relieve the suffering of these patients. This report was one of 40 publications initiated or aided by 2C North nurses.

2C North is a model nursing unit. In this environment, nurses can develop their full abilities regardless of academic background. They are given the opportunity to develop patient management programs and the flexibility to implement them. Nurses not only give care, they develop better care.

[*] Johnston-Early, Anita, and others. Smoking abstinence and small cell lung cancer: an association. *JAMA* 244:2175-2179, Nov. 14, 1980

[**] Paper presented at American Society of Clinical Oncology meeting, May 24, 1983

Proc Am Soc Clin Oncol 2:91, 1983

C-353*

THE SAFETY OF CONTINUOUS INTRAVENOUS MORPHINE (CIVM) FOR INTRACTABLE CANCER PAIN OR DYSPNEA. M.L. Citron, A. Johnston-Early, B.E. Fossieck, Jr., S.H. Krasnow, and M.H. Cohen. VA Medical Center, Washington, D.C.

Pain and/or dyspnea are common symptoms experienced by patients with solid tumors. CIVM is one approach to the therapy of these problems, but may be hazardous in debilitated patients. This study evaluates the safety of this mode of therapy. Eligible patients had intractable pain unrelieved by oral narcotics. Bolus IV injections of 2-4mg of morphine were given every 10 minutes until patients reported relief of pain. Within the next hour a CIVM infusion was begun; hourly dose equal to the cumulative bolus dose. Respiratory rate, pulse, blood pressure, arterial blood gases, mental status, and pain relief were recorded at baseline and during the study period. Ten solid tumor patients ranging in age from 46 to 64 years had 13 courses of CIVM. Pretreatment studies revealed a mean respiratory rate of 21/min (range 13-32), PO_2, 73 torr (range 48-94), PCO_2, 40 torr (range 33-51). Initial bolus, infusion hour 4, and peak hourly IV morphine doses were 18 mg (range 2-58), 20mg (range 2-50) and 39mg (range 2-140) respectively. In 5 trials final maintenance IV morphine doses were 100% greater than the initial dose. A decrease in respiratory rate 40% below baseline was seen in 7 trials, reduction in PO_2 20% below baseline in another 7, and an increase in PCO_2 20% above baseline in 3. Major relief of pain and/or dyspnea was achieved in 12 trials. One case of life-threatening toxicity occurred during the 14th hour at a dose of 20mg/hour and was heralded by bradypnea and marked somnolence. Morphine was stopped, no antagonist given and the patient recovered. In conclusion, CIVM appears to be safe. Bradypnea associated with marked somnolence is a cause for dose reduction.

C-354*

A RANDOMIZED COMPARISON OF CEFTAZIDIME (Cef) VS CEPHALOTHIN, CARBENICILLIN AND GENTAMICIN (KCG) IN FEBRILE (F+) GRANULOCYTOPENIC (G+) CANCER PATIENTS (pts). B.S. Kramer, J.J. Jones, R. Ramphal, K. Rand, A. Santoro. University of Florida, Gainesville, FL 32610

We are comparing the effectiveness of Cef to KCG as initial empiric therapy in F+ G+ (<500 polys and bands/mm^3) cancer pts (median age 43; range 20-88 years). To date, there are 41 evaluable episodes (20 Cef, 21 KCG). A favorable clinical response (temperature <38°C within 4 days lasting >48 hours) occurred in 8 of 20 episodes (40%) with Cef compared to 12 of 21 episodes (57%) with KCG ($p>0.2$). Within a high risk group (granulocytes <500 for >7 days) clinical response rates were the same on each regimen (5/12). All low risk patients had a favorable clinical response. The 5 initial bacteremias in Cef pts (E. coli x 2, Pseudomonas, Klebsiella, Clostridium) were cleared except for one E. coli. The 4 initial bacteremias in KCG pts (Pseudomonas x 3, Enterococcus) were cleared except for one Pseudomonas. Superinfection occurred in 6/20 Cef episodes at a median of 12 days (2 Clostridia, 2 Enterococcus, 1 Bacillus, 1 Citrobacter) and 8/21 KCG episodes (2 fungal, 4 Pseudomonas, 1 E. coli, 1 Bacteroides fragilis) at a median of 18 days. 7 KCG pts developed hypokalemia ($K^+ < 3.5$meq/L) compared to 2 Cef pts. Neither group had significant change in BUN or creatinine. There were 6 deaths in the Cef group (4 infectious) compared with 5 deaths in the KCG group (3 infectious). This preliminary analysis suggests that Cef alone may be comparable to KCG in the empiric therapy of F+ G+ cancer pts with presumed infection. The patterns of superinfection may differ with more gram positive organisms in the Cef group and more fungal and gram negative organisms in the KCG group.

C-355

ASSESSMENT OF COAGULATION PROBLEMS IN PATIENTS WITH CANCER RECEIVING EMPIRIC ANTIBIOTIC THERAPY. A.E. Brown, O. Quesada, J.A. Murrer, J. Eason, D. Armstrong, and S. Kempin. Memorial Sloan-Kettering Cancer Center, New York, N.Y. 10021. (Introduced by P. Sherlock)

Abnormalities of coagulation including platelet dysfunction have been described with various antibiotics. These problems were assessed in an ongoing study of the empiric treatment of sepsis in febrile, neutropenic patients with cancer, whose therapy was randomized to tobramycin in combination with either ticarcillin (TIC), moxalactam (MOX), or piperacillin (PIP). Prothrombin time (PT), transfusion requirements (RBC and platelet), and evidence of clinical bleeding were determined. Of 136 episodes randomized, there were 120 patients: 32 leukemia; 15 lymphoma; 50 solid tumor; and 3 aplastic anemia; 61 males and 59 females; ages: 8 months to 84 years, mean = 28.0 years. Prolonged PT (↑PT) could be assessed in 62 episodes, of which 16 became prolonged during therapy: 6 of 26 TIC; 8 of 16 MOX ($p<0.03$); and 2 of 20 PIP. The mean time it took for the PT to become prolonged was 11 days (range = 2 to 30 days).

Transfusion Requirements*

	RBC		Platelet	
	↑PT**(16)	Others(46)	↑PT**(16)	Others(46)
TIC	0.32	0.28	3.48	1.35
MOX	0.39	0.21	2.54	0.71
PIP	0.83	0.30	2.89	1.94

* units/day ** ≥2 seconds above control PT

All 136 episodes were considered evaluable for bleeding. Bleeding developed in 7 of 46 TIC; 6 of 44 MOX; and 2 of 46 PIP. ↑PT was significantly more frequent in the MOX group. While evidence of bleeding was no different among treatment groups overall, RBC transfusion requirements were increased in the PIP group with ↑PT, and platelet transfusion requirements were increased in all 3 groups with ↑PT.

C-356*

COMBINATION ANTIEMETIC TRIALS WITH METOCLOPRAMIDE (MCP). LB Tyson, RJ Gralla, RA Clark, MG Kris. Memorial Sloan-Kettering Cancer Center, New York, NY 10021.

MCP has demonstrated safety and antiemetic efficacy when given in high intravenous doses to patients (pts) receiving cisplatin (DDP). Consecutive trials with 86 pts were undertaken to see if agents added to MCP would improve the response rate without increasing toxicity. Dexamethasone (Dex) and diphenhydramine (Diphen) were added to MCP based on reports of efficacy of the former, and a decrease of MCP side-effects from the Diphen. All pts received DDP 120mg/m^2 IV as their initial chemotherapy. In each of the trials MCP was given at 2mg/kg IV, 30 mins before DDP and then every 2 hours for 3 doses, except in regimen I in which 5 doses of MCP were given. In regimens II-IV, Dex was given at 20mg IV with the first dose of MCP. The Diphen dose was 25mg IV in regimen III given with the first and second MCP doses; in regimen IV, 50mg of Diphen was given with the first dose of MCP only. The results were:

REGIMEN	N	No Emesis	0-2 Episodes	% with Diarrhea
I-MCP alone	36	39%	64%	39%
II-MCP+Dex	25	60%	88%	12%
III-MCP+Dex+Diphen 25mg	10	60%	80%	0%
IV-MCP+Dex+Diphen 50mg	15	66%	93%	8%

In all trials with Dex (regimens II-IV) improvement in antiemetic response rates occurred. Sedation was mild in all cases and only slightly increased in pts receiving Diphen. No steroid related toxicity occurred. Extrapyramidal reactions occurred in one patient with MCP alone (3%); no patient receiving regimens II-IV had this effect. These results indicate that: 1) the addition of Dex to MCP improves antiemetic control; 2) early results suggest further improvement with Diphen 50mg added to Dex+MCP; 3) combination regimens are associated with fewer side-effects. Supported by NCI grant CA-05826 and by A.H. Robins Company.

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THERAPEUTIC TOUCH: PRELIMINARY ASSESSMENT OF EFFICACY.
M.L. Raucheisen, VA Medical Center, Washington, D.C.
20422

Therapeutic Touch (TT) is being increasingly used by the nursing profession to relieve a variety of patient symptoms. Most reports indicating beneficial effects of TT are annecdotal, however. To provide objective documentation of efficacy a patient interview questionaire was designed. This was filled out, during the evening shift, prior to TT and was filled out again the next evening. Questions dealt with 1) general feeling of well-being 2) appetite, 3) nausea, 4) vomiting, 5) overall assessment of sleep 6) number of hours of sleep 7) number of waking-up episodes at night 8) feeling of refreshment after sleep 9) pain-location and severity and 10) feeling of relaxation. Questions 1, 2 and 5 were answered good, fair or poor, questions 3, 4, 8, 10 were answered yes or no and the remaining qusstions were answered quantitatively. Nine trials were conducted in 6 advanced cancer patients admitted for chemotherapy and one trial was in a resectable lung cancer patient. Comparing pre and post TT responses the number of patients trials demonstrating benefit from TT for each of the above 10 categories is listed

Category	Percent Pts Benefiting	Category	Percent Pts Benefiting
well-being	30	# hrs sleep	70
appetite	10	# waking episodes	60
nausea	30	sleep refreshment	20
vomiting	0	pain	70
overall sleep	50	relaxation	75

From this preliminary data TT appears to be of benefit for relaxation, pain relief and for improving quantity and quality of sleep. This latter finding is of interest since since sleep disturbances, in hospitalized patients, are common. This study is on-going. The questionaire is being validated in control patients not receiving TT.

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HICKMAN CATHETERS (HC) IN PATIENTS (PTS) WITH SOLID TUMORS AND LEUKEMIA. S. Krasnow, M. Boyer, G. Rhodes, O. Gaspar, M. Citron, A. Johnston-Early, L. Murphy, M. Cohen, VA Hospital, Washington, D.C. 20422 (Sponsored by S. Krasnow)

To determine the safety and efficacy of long term central venous catheters in our oncology pt population, HCs were placed in 59 pts for chemotherapy (CT) administration between 10/81 and 11/83. Pts were excluded if they refused but rarely was a pt excluded for anticipated noncompliance. Forty-five pts had solid tumors (20 lung, 15 head and neck, 6 esophagus, 4 other; 14 had hematologic malignancies. HCs were usually placed into the right subclavian vein under fluoroscopic guidance. HCs were flushed daily with 5cc heparin (100U/ml). Pts were taught their own HC care to allow discharge between CT treatments. HCs were used for blood sampling, administration of CT, blood products, intravenous fluids, antibiotics, other medications when indicated, and for parenteral nutrition. The mean duration of HC placement was 71+ days (range 2-570). Premature removal occurred in 6 cases. Reasons included HC occlusion (1), dislodgment (4), and for chemotherapy-induced jugular vein phlebitis after secondary migration of a HC tip (1). No instance of documented sepsis occurred despite neutropenia on several occasions in most pts. Twenty-six pts died with their HC in place; 6 had removal at the completion of CT. Eight repairs of 6 externally damaged catheters were performed with a standard kit. Twenty-six pts (44%) had one or more episodes of selective outflow obstruction relieved in 19 (73%) with low dose streptokinase through the HC. Pt acceptance of HCs was almost universal. No pt continuing CT requested HC removal and all nurses felt that HCs saved time and effort over performing venipuncture. Our experience demonstrates that HCs are safe in a pt population at high risk for inducing catheter complications, and that HCs contribute greatly to reducing pt discomfort and facilitating care.

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DROPERIDOL (DP): OPTIMAL DOSE AND TIME OF INITIATION. M.L. Citron, A. Johnston-Early, M.W. Boyer, S.H. Krasnow, D.A. Priebat, M.H. Cohen. V. A. Medical Center, Washington, DC. 20422. (Sponsored by D.A. Priebat)

Escalating doses of DP were tested for antiemetic efficacy and toxicity during 300 courses of combination chemotherapy. We evaluated IV loading doses of 1.0mg-20mg, IV maintenance doses of 1.0mg-10mg, and IV dose intervals of 2-4 hours. The optimal schedule established was a 15mg loading dose followed by 7.5mg IV q 2 hours for 7 doses. This regimen was evaluated in 40 male inpatients who received 100 courses of cisplatin-based combination chemotherapy. These patients had a mean age of 53 years (range 37-63), a median BSA of 1.8m^2 (range 1.5-2.2), and performance status of 0-2. Complete responses (0 emetic episodes) occurred in 42 trials; partial responses ($\leq$ 3 emetic episodes) in 49 trials; and poor responses in 9 trials. The most common side effect was mild to moderate sedation from which patients were easily aroused. Vital signs remained near baseline in most trials. Uncommon side effects included dystonia (1), confusion (1), subjective difficulty of breathing (2), and marked somnolence (1). These side effects, except dystonia, abated by reducing or holding the next dose. Dose limiting toxicities of higher DP doses were confusion and marked sedation. We then began a double-blind randomized crossover study to determine whether the time interval between starting DP and giving chemotherapy would influence the severity of anticipatory or post-chemotherapy nausea and vomiting. In this study, two different DP schedules are being evaluated: DP begun either 5 hours or 1 hr prior to chemotherapy. Patients are randomly assigned to receive one schedule for the first cycle of chemotherapy and the companion schedule for the second cycle of treatment. To date, results of this study are still coded.

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Mr. **Principi.** Ms. Dreyer.

Ms. **Dreyer.** Thank you. I am Sharron Dreyer, assistant administrator, Patient Care Services, Hospice of Northern Virginia. The written testimony that you have before you gives you the facts, figures, and measurable data that we have gathered in our program over the past several years. We have been providing home care for more than 6 years, inpatient care for the last two.

We believe that hospice is comprehensive, coordinated care which provides home care, inpatient backup and bereavement followup to families through the first anniversary of a patient's death.

What is not included in my written testimony is the soft data or the harder to define, much less measure issues, about quality of life, patient/family satisfaction and the opportunity to deal with bringing one's life to a close in a personal, meaningful way. There are hard to measure intensity levels in the amount of care provided to terminally ill patients to promote hospice goals.

It is not uncommon to hear people say, we have been caring for the terminally ill for years and, therefore, we have been providing hospice care. I believe that hospice care is different. It is coordinated, comprehensive interdisciplinary care which deals with patients and their families as a unit.

It is provided on a continuum from home care to inpatient care with family support. It is labor intensive. It is personal care. I happened to be at my office on Saturday, which is unusual, working on this testimony and received a call from a young woman from out of State whose mother had died in northern Virginia without the benefit of hospice care, primarily because of misinformation about what hospice care was. This young woman's frustration led her to question me, after a lengthy conversation, as what can I do to see to it that other people do not have to go through what my mother went through:

> How can I help notify the doctors who are responsible for her care about what hospice care is?
>
> My mother would have been a perfect hospice candidate. She wanted to be at home. We were available to provide care for her at home. We were there to be supportive. We lacked information about what hospice was.

That is a telling story. Sixty-seven percent of our patients are able to die at home.

I think hospice needs to be an option or a choice that patients have and I would encourage this committee to recommend that the VA explore community options for hospice care, that they not only focus on care for terminally ill veterans within inpatient settings, but that they explore community options, that they explore providing hospice care to veterans who are residing in old soldier homes, in personal care homes and whatever other settings they are currently relating to in terms of caring for veterans. I would encourage you to explore creating options to provide hospice care in any or all of those settings.

I would like to share with the committee three unsolicited sentences from family members following care of their loved ones.

> The hospice staff allowed us to make all of the decisions, within reason of course. You were supportive when needed and yet gave us the privacy and intimacy we needed during the last moments of his life.

The second young man wrote:

> I was most impressed with the high level of technical skill and competence of the staff in all departments and at all levels. But beyond professional abilities you provided a warmth and understanding which has been of invaluable help to dad and our family.

And the third man wrote:

> Knowing my brother could not manage for himself, he still wanted to be in charge, and hospice allowed him this freedom. From the first visit to our house for a preadmission visit to the moment the nurses stood with us by his bed as he drew his last breath in sleep and without pain, the hospice staff and volunteers provided a haven of caring, dignified, mature human love for my brother. We are grateful.

If we had more time, I could share more of these with you. The main point I wish to make is that I understand the necessity for cost containment. I also know that statistics and research are important. People are important too. I would encourage this committee to explore as many options as possible for providing comprehensive hospice care in whatever settings veterans may be located, in their own home, in the community, in an inpatient setting, if that is appropriate for management of that particular patient, and also I encourage you to support bereavement followup for families.

Thank you.

Mr. PRINCIPI. Thank you.

[The prepared statement of Sharron Dreyer, B.S.N., assistant administrator, Patient Care Services, Hospice of Northern Virginia, Inc., Arlington, VA, follows:]

PREPARED STATEMENT OF SHARRON DREYER, B.S.N., ASSISTANT ADMINISTRATOR, PATIENT CARE SERVICES, HOSPICE OF NORTHERN VIRGINIA, INC., ARLINGTON, VA.

I am Sharron Dreyer, Assistant Administrator for Patient Care Services at Hospice of Northern Virginia.

Hospice of Northern Virginia is a community-based, freestanding, non-profit organization designed solely to provide hospice services to our community. We are licensed by the Commonwealth of Virginia and certified by Medicare as a home health agency. Our inpatient facility is licensed and is Medicare certified as a hospital. We are one of the 26 sites in the national demonstration sponsored by HCFA and are in the process of becoming certified under the new hospice program in Medicare. We also participate in a hospice demonstration under the local Blue Cross Plan, Group Hospitalization, Inc. (GHI), which now offers the hospice benefit to most of its non-Federal contracts based on that demonstration.

Hospice of Northern Virginia has six years' experience in providing home care to a geographic area including four counties and five towns and encompassing a population of more than one million in a 100-square-mile area.

Criteria for admission to our home care program include

- -- residency in our service area
- -- no further active treatment for cure
- -- life expectancy estimated to be no longer than six months
- -- desire and consent of the patient to Hospice care (philosophy, goals and services available)
- -- willingness of a family member or other appropriate person to assume responsibility for care and decision making
- -- medical, nursing and psychosocial needs that can be adequately and safely met by the Hospice program in patient's residence.

Hospice provides a full range of services utilizing an interdisciplinary team approach. Core team members include physician, nurse, social worker, chaplain and volunteer. Additional members may include home health aides/nursing assistants, dietitian, and therapists, such as occupational therapists, physical therapists, speech therapists. Care is provided to patients and their families according to a plan of care that is jointly developed and reviewed frequently. In our program, care is provided in the patient's home if at all possible and our own inpatient facility is available for short-term stays when home care is not appropriate. Bereavement services are available to families through the first anniversary of the patient's death.

Hospice home care is the basis of our program and over 1,300 patients have been served. Our experience shows that, given the full range of hospice services, it is possible to care for most terminally-ill patients at home.

Selected data from our 1983 experience show

- 67% of home care patients died at home
- 21% died in our inpatient unit
- 11% died in acute-care hospitals
- the average length of stay in the home care program was 43 days
- the total group of home care patients received an average of
  - 10 nursing visits
  - 1.5 physician visits
  - 1.6 social worker visits
  - .5 chaplain visits
- 61% of home care patients used the services of a home health aide, with an average of 205 hours per patient
- volunteers visited patients an average of 5 times
- 60% of our patients were over 65 years of age
- 51% of our patients were female; 49% were male

-- the average cost per day of providing home care in 1983 was $92.30[1/]

Because of this experience, we know we are avoiding expensive acute care hospitalization for our patients. Most patients without hospice care (70% estimated in a local Blue Cross study) die in acute care facilities. In a random sample of claims in terminal palliative acute care, the local Blue Cross (GHI) found the average cost in this final admission to be $503 per day.

Hospice inpatient care as a back-up to home care is an essential component of a hospice program. Hospice of Northern Virginia had nearly four years of experience without the availability of hospice inpatient services and, in a very real way, knows the limitations (in terms of both quality and cost) of having only a partial program of care.

Our inpatient facility is a 15-bed unit located in a quiet residential area of Arlington. It originally was an elementary school, which was donated to Hospice for the purpose of conversion to an inpatient hospice. Esthetically, the design incorporates the Georgian architecture of the building, making use of the large windows and airy space. Acknowledging that we do have hospital beds, geri-chairs, piped-in oxygen and other equipment,

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[1/] Includes both routine home care and continuous home care. Routine home care consists of visits made by members of the interdisciplinary team; continuous home care consists of shifts of care provided by home health aides, licensed practical nurses or registered nurses in cases of medical crisis.

the general tone of the unit is homelike. Soft colors are used throughout -- all the rooms are wallpapered, upholstered furniture is in use, and homelike touches are apparent. We do our own food preparation, we permit visiting at any hours, and we encourage family members to participate in care and learn new techniques in caring for patients at home.

The inpatient unit at Hospice of Northern Virginia, which serves the metropolitan area of Washington, D.C., is designed for short-term stays when home care is not possible and as a substitute for acute hospital care. A careful and thorough assessment takes place prior to admission, with regular review thereafter, so that appropriate stays are assured. Patients coming into our inpatient unit are very ill and require a high level of care. These patients would be in an acute-care hospital if hospice inpatient care were not available. Reasons for admission include, but are not limited to

- the need for pain control and management
- other symptom management, such as intractable nausea and vomiting
- acute respiratory distress
- open lesions requiring frequent professional care
- unstable or multiple medical conditions such as hemorrhage, seizure activity, mental status changes, extreme anxiety or functional decompensation of the home care family
- imminent death (within one to two weeks)

Staffing on our inpatient unit consists of four registered nurses and two nursing assistants on the 7-3 shift and three registered nurses and two nursing assistants on the 3-11 and 11-7 shifts. This pattern is consistent seven days a week and our nursing staff/patient ratio is always a minimum of one to three. The average number of all nursing hours per patient per day is nine.

Selected data from our 1983 inpatient experience show

- -- an average length of stay 18 days (for all patients), 12.7 days for patients from our home care program
- -- 81% average occupancy rate
- -- 65% of our patients over 65 years of age
- -- 42% of our patients male; 58% female
- -- an estimated $293 total cost per patient per day in 1983 including all ancillaries

The time of bereavement is a complex time of need. Grief is not an illness but a natural process. The bereavement care program is, therefore, not treatment oriented, but is set up as a preventive, supportive and educational program. We help bereaved family members understand what they are going through so that they have more control and more choices. We give bereaved persons support during a time when their world is very shaky and there seems to be no steady ground. We help persons to use their existing support systems as well as to develop new ones. We share our own and others' coping mechanisms and styles and encourage the bereaved to use their past coping styles and to develop new ones.

Bereaved persons need encouragement and support to build a new life separate from their deceased loved one. The bereavement team enables this by going through, being with, being available to the person during the difficult seasons of grief. The bereavement team allows dependence as it is needed, but always encourages independence as time goes on -- encouraging the bereaved to begin connecting to his/her own community, family, church and other organizations. Our bereavement program provides services to families through the first anniversary of the patient's death. In 1983 we admitted 391 new families to our program which consists of individual staff and volunteer contacts, group sessions and social and educational programs.

As you have seen, the emphasis in hospice is home care with family involvement and support. We encourage the exploration of veterans receiving hospice services in their own community whenever possible. Perhaps arrangements with local hospices would meet those needs.

With our experience we have been concerned about another issue. That concern is for those patients who do not meet the short-term, acute care criteria of inpatient hospice care but, due to the absence of a primary care-giver or adequate living arrangements, cannot be cared for in our home care program. Locally we are exploring creative alternative placement arrangements which will allow us to provide care and support to these patients but we are hampered by existing reimbursement restrictions. Since many veterans may fall into this situation and since the Veterans Administration already relates to nursing homes, personal care homes and domiciliaries, it would appear logical that you explore the possibility of arrangements with community hospices to provide services to terminally ill veterans residing in such environments as well as in their own homes.

Let me conclude with a review of some of the essential characteristics of Hospice care. Hospice provides comprehensive, coordinated services for patients in the last several months of life. This service is provided by a physician-directed, interdisciplinary team of professionals and volunteers. Hospice emphasizes maintaining patients in their own homes for many reasons, including the well-documented cost savings as well as the quality of life of patients who choose to live their last days at home rather than in acute care settings. Recognizing that home care is not always possible, inpatient services need to be available which continue the comfort and supportive aspects of care rather than cure-oriented treatments and procedures. As I hope my testimony has indicated, hospice is special labor-intensive care for patients and their families who are facing the exhausting time of terminal illness.

Statement of Philosophy

Hospice is a choice which should be carefully considered by patients, families, and attending health care professionals.

Hospice is an integrated program of medical and psycho-social care for terminally ill patients in their last several months of life. It is founded on the belief that the final stages of life should be lived with the greatest degree of comfort and dignity possible.

Hospice recognizes death as a normal process which should neither be hastened nor unnecessarily postponed when in the judgement of the physician, patient, and family, there is nothing more which can be done to effect a cure. Hospice affirms life by providing the care and support necessary to enhance the quality of life remaining for the patient. Hospice care is palliative (i.e. not curative). Its aim is to manage pain and other symptoms so that patients can remain comfortable and at an optimal level of functioning. Patients are encouraged to retain control of their own lives and to assist in the decision-making process.

The Hospice philosophy emphasizes maintaining patients in their own homes. Inpatient care is available when the level of care required mitigates against home management. Whenever possible the aim of inpatient care is to enable the patient and family to return to home care.

Terminal illness affects every member of the family. Hospice care includes both patient and family as the primary unit of care. Family members are supported in their efforts to care for the patient themselves and to prepare for the impending death. In addition, the bereavement program helps family members resolve their grief following the patient's death.

Realizing that no one person can address all the physical, sociological, psychological, and spiritual needs of the dying patient and family, Hospice utilizes an interdisciplinary team of caregivers to meet those needs as completely as possible.

Hospice is a choice which should be carefully considered by patients, families, and attending health care professionals. Hospice is not necessarily the preferred choice of every dying patient. However, for many patients and families who are facing the exhausting crisis of terminal illness, Hospice offers the most appropriate form of care and can help patients bring their lives to a close with a sense of comfort, control, and completion.

from The Hospice Choice: Is It Right for Your Patient?, published by Hospice of Northern Virginia, Inc., 1983.

Essential characteristics of Hospice care

- **CENTRALLY ADMINISTERED PROGRAM OF COORDINATED HOME CARE AND INPATIENT SERVICES FOR TERMINALLY ILL PATIENTS IN THE LAST SEVERAL MONTHS OF LIFE.** Primary emphasis is placed on maintaining the patient at home.

- **PHYSICIAN—DIRECTED INTERDISCIPLINARY TEAM APPROACH.** The team includes a physician, nurse, social worker, chaplain, and trained volunteer.Other health care professionals such as home health aides, physical therapists, and a wide variety of consultants may be added to the team as necessary. All members of the team make home visits.

- **PATIENT AND FAMILY AS THE PRIMARY UNIT OF CARE.** Terminal illness affects each family member. The patient and family are actively encouraged to make decisions about hospice care.

- **PALLIATIVE, NOT CURATIVE, TREATMENT.** Physical pain, nausea, and other symptoms are controlled as effectively as is medically possible. Care is directed toward emotional and spiritual pain as well.

- **SERVICES AVAILABLE ON CALL, 24 HOURS, 7 DAYS A WEEK.** The staff is available to make home visits whenever necessary.

- **TRAINED VOLUNTEERS.** Volunteers are carefully selected and trained to supplement the care given by professional staff. They provide non-clinical support to patients and families.

- **BEREAVEMENT FOLLOW-UP.** Individual and group support is extended to families in grief in the first 13 months following the patient's death.

- **SERVICES BASED ON NEED.** Hospice services are available to all eligible patients regardless of their ability to pay.

- **INFORMED CONSENT.** Understanding the hospice philosophy, patients must agree to hospice care.

from The Hospice Choice: Is It Right for Your Patient?, published by Hospice of Northern Virginia, Inc., 1983.

Mr. **Principi**. It has been said that better management of pain and symptoms is a medical skill that can be conveyed by better education. The hospice movement may have made its contribution by sensitizing practitioners to this deficit. Such care does not require formal designation as a hospice.

Do you agree with this statement? If so, why, and if not, why not?

Ms. **Dreyer**. Yes, I agree that managing patients' pain is not unique to hospice and if we could work ourselves out of business in 100 years or 25 years because every patient in every medical setting was receiving individualized patient care tailored to his particular needs including management of his pain, because all members of the health-care professions knew how to do that, that would be fine with us.

Mr. **Principi**. Doctor.

Dr. **Cohen**. I would agree also on that question. We uniformly see that house officers who rotate to our oncology ward have little knowledge about pain control and about its appropriate treatment. When these house officers leave our service after a month or two, they know how to provide pain control. I think it is an easily taught skill, that only requires a knowledgeable, compassionate staff, and appropriate patients.

Mr. **Principi**. Do you have any recommendations to VA on how they could teach this skill or publicize this type of care?

Dr. **Cohen**. The VA cannot mandate teaching. Teaching depends on the people you have doing the teaching and the availability and interest of the students and the availability of appropriate patients. I think the medical literature has recently devoted a lot of attention to pain management and possibly this will stimulate more effort into teaching pain management. I cannot see the VA mandating that pain control be taught.

Mr. **Principi**. There is disagreement among health-care planners and policymakers regarding the cost effectiveness of hospice care. What are your views on its cost effectiveness?

Dr. **Cohen**. I think that there is an ongoing national study that looks at the question of cost effectiveness of hospice care. My problem with hospice is that it is difficult to define exactly what hospice is. The philosophical concept of hospice is widely accepted as the appropriate standard for the care of the terminally ill. Beyond that, however, hospice is continually evolving. The kinds of patients referred to hospice when the concept started in this country in the mid-1970's are not the kind of patients that come to hospice these days. In those days there were very few oncologists in practice, so that fairly ambulatory patients were admitted to a hospice program. They required an entirely different spectrum of care than the current patients who are admitted to hospice programs.

Currently, because many more oncologists are in private practice, it is my impression that patients are kept by the private doctor until very close to the end of their road. If that is the case, then the kinds of management that the hospice has to provide are greatly different than if you have patients who have about a 6-month life expectancy and who are completely ambulatory when they are first admitted to a hospice program.

To determine questions of cost effectiveness I think that you need detailed information about the type of patient being referred for hospice care, how sick he is, and how long he survives from the time of referral. This will help indicate appropriate cost levels for his care.

Mr. PRINCIPI. Ms. Dreyer.

Ms. DREYER. Our average length of stay in our home-care program in 1983 was 47 days. We would like to see that length of stay increased. We feel we can do a better job of providing care to patients and families if they are in our program a longer period of time, primarily because we can do a lot of patient/family teaching and anticipating and prevention of problems before they occur.

We project that our costs per day for a home-care patient in 1984 will be around $74 a day. That is certainly considerably cheaper than a patient spending $500 a day in an inpatient setting, or in an acute care hospital setting. Our costs for inpatient care is in the ballpark of $300 per day.

My written testimony speaks to the level of nursing care provided to the patient/staff ratio. I think those are important things to look at. Our patients who are in our inpatient facility are sick folks, but we also manage patients at home who are acutely ill and many of them could be in an acute-care hospital and be appropriate for care there. But they have chosen to receive their care from hospice and spend their last days at home rather than in an acute-care setting.

Mr. PRINCIPI. Would the home base model be the most cost effective or do we still need to do more research?

Ms. DREYER. I think it never hurts to continue doing more research. Our own personal feeling is that if there is a comprehensive hospice program that provides the whole scope of service, then you keep people in the setting that is most appropriate for their own particular needs. That is why we feel hospice needs to be a comprehensive program which can provide care at home when that is appropriate and manageable and yet have a hospice inpatient backup for those people who cannot be maintained at home.

Dr. COHEN. You speak of cost-effective methods and it is fairly easy to quantitate costs, but it is very difficult to evaluate effectiveness. People use various scales to measure parameters of pain control, life satisfaction, quality of life, et cetera. Whether those scales are really meaningful and get at what is really pertinent to relief of patient suffering is still open to question. That is the aspect of the problem, that it is difficult to evaluate.

Mr. PRINCIPI. If we have any more questions, we will submit them for the record. Thank you very much.

[The responses of Martin H. Cohen, M.D., chief, Oncology Section, Veterans' Administration Medical Center, Washington, DC, and Sharron Dreyer, B.S.N., assistant administrator, Patient Care Services, Hospice of Northern Virginia, Inc., Arlington, VA, to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, and Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follow:]

RESPONSE OF MARTIN H. COHEN, M.D., CHIEF, ONCOLOGY SECTION, VETERANS' ADMINISTRATION MEDICAL CENTER, WASHINGTON, D.C., TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. Hospice care is reported to result in savings due to the use of fewer ancillary services compared to non-hospice care for the terminally ill. Do you believe such savings are outweighed by increases in cost due to higher staff-to-patient ratios and greater hours of nursing care provided per patient?

Answer 1.

I think that while hospice care will be cheaper than current standard medical care, the savings will not be great. Terminally ill patients, like any other patients, require optimal, appropriate medical care. They are "sick" individuals who often develop acute problems requiring active medical and/or surgical intervention for effective, symptomatic palliation. A physician must, therefore, direct the care of the terminally ill and nurses must continue to be the primary providers of care. These patients and their loved ones also require multidisciplinary professional assistance to meet their psychological and spiritual needs. All of these staff costs are required whether the patient is cared for in a hospice-type setting or in an acute care hospital. Hospice philosophy may result in cost savings through 1) the recognition that ongoing curative strategies are no longer appropriate and 2) the hospice orientation toward more home-based care. Changing the criteria for successful treatment from cure to successful palliation should 1) eliminate a considerable amount of unnecessary, expensive diagnostic testing and 2) eliminate costly disease-related treatment programs that have a very low possibility of benefitting the patient. Emphasis on home-based treatment will obviously reduce the cost of stay in an inpatient facility. Hospice programs may reduce physician costs slightly because a physician will see a patient less often if he is at home than if he is in an inpatient facility. I do not think there can be a reduction in nursing costs without deterioration in the quality of terminal care and I think that there might be a cost increase related to meeting the psychological and spiritual needs of the patient and his family.

Question 2. Would you estimate that the cost of a hospice bed in an inpatient facility is comparable to that of a general medical bed, and intermediate care bed, or a nursing home bed?

Answer 2.

Some of the considerations that went into answering your first question also apply to this question. The goal of management of patients admitted to a general medical bed in an acute care hospital is "cure". To achieve cure no diagnostic test or potentially useful therapeutic modality is spared. Costs of this type of care are necessarily high. Nursing homes, in contrast, generally provide custodial care. They usually do not have sufficient professional staff to meet the needs of terminally ill patients. The closest comparison of costs of hospice care would probably be to an intermediate care bed although the type of care needed by the terminal patient, as suggested in my answer to your first question, is considerably different from that needed by the usual patient in an intermediate care bed.

Question 3. In your experience, what is the most important component in providing care to the terminally ill?

Answer 3.

I think that there are 2 equally important components. The first is relief of distressing symptoms, especially pain and dyspnea control and the second deals with bereavement. While optimal symptom relief, as stated in my written testimony, is still a future goal the hospice philosophy, at least as regards pain management, is an important step in that direction. My thoughts about bereavement are summarized in my letter to Senator Cranston who questioned me about this issue. I enclose a copy of this letter.

I want you to know that I am deeply concerned about the issues of terminal care. I think that we have a long way to go before patients are sufficiently symptom free to achieve satisfactory mental and spiritual preparation for death.

Medical Center

50 Irving Street, NW.
Washington D.C. 20422

Veterans
Administration

April 17, 1984

In Reply Refer To:

Honorable Alan Cranston
Ranking Minority Member
Committee on Veterans Affairs
United States Senate
Washington, D.C. 20510

Re: Section 3 of S 2269

Dear Senator Cranston:

In response to your letter suggesting bereavement counseling for up to 6 months after death, I would like to share with you some of my views on the bereavement process.

Bereavement starts as soon as the patient and his loved ones are told that death is inevitable. All parties affected by this knowledge suffer and grieve because lifelong ties are about to be broken. The patient suffers from feelings of loneliness and isolation from his family and from helplessness in the face of his illness. His loved ones also suffer because of their inability to adequately help the patient. Family planning for the future is often delayed or ignored because plans must obviously exclude the dying patient. As time passes, the patient progressively deteriorates physically and mentally until only fragments of his personality remain. During this last period, the loved ones begin to hope that death will come soon. This wish often engenders guilt.

In light of these considerations, it is clear that bereavement counseling should start at the time a terminal illness is diagnosed, not after death. My staff and I have recognized this need for many years and reference is made to bereavement in the bracketed section of the attached article (p.1183) describing our oncology ward. Our concern about bereavement and the shortcomings in treating it have led us to develop a protocol to guide our management of grief and anguish. Hopefully, with adequate funds for personnel, this type of program could be widely implemented in VA medical centers. Briefly, we plan to foster an interaction among the patient, his loved ones and specially motivated nurses who are either trained or long experienced in dealing with the concerns of the terminally ill. Together, they will form a therapeutic alliance. This alliance will begin with the establishment of a trusting relationship. Subsequently, practical problems will be worked out, personality assets capitalized upon and remaining patient resources utilized. This leads into the therapeutic phase where preparation is made for the termination of the relationship. Discussion, in the therapeutic phase, centers around concepts of life, death and afterlife. The theory of eternal progression is often a gratifying speculation that encourages both patient and family toward achievement and optimism even in the face of imminent death. By forming a therapeutic alliance between the patient, mediating nurse and his family, both hidden and obvious personal values are brought into focus so that all affected individuals derive support and solace throughout the terminal illness and beyond. We stress that last achievements and struggles are worth the effort, that they can be satisfying and that they may be carried into the next phase of existence. In the final days, the therapeutic alliance between the nurse and the family helps them deal with their feelings of guilt and inadequacy in the face of death. By the time the patient dies, much of the bereavement process should have been accomplished, and the family should feel relief that the patient's suffering has ended. This should help them to make the adjustments needed to continue their lives.

To specifically answer your question, I agree that bereavement counseling is very important. Because bereavement is not yet adequately managed it could require six months of counseling, after death, for adjustments to be made. As indicated above, however, this is not optimal. Our goal is to develop techniques that will allow bereavement counseling to be concluded, in most cases, at the time of death. We are optimistic that this can be achieved.

Sincerely,

Martin H. Cohen, M.D.
Chief, Oncology Section

HOPE ALL THINGS, ENDURE ALL THINGS

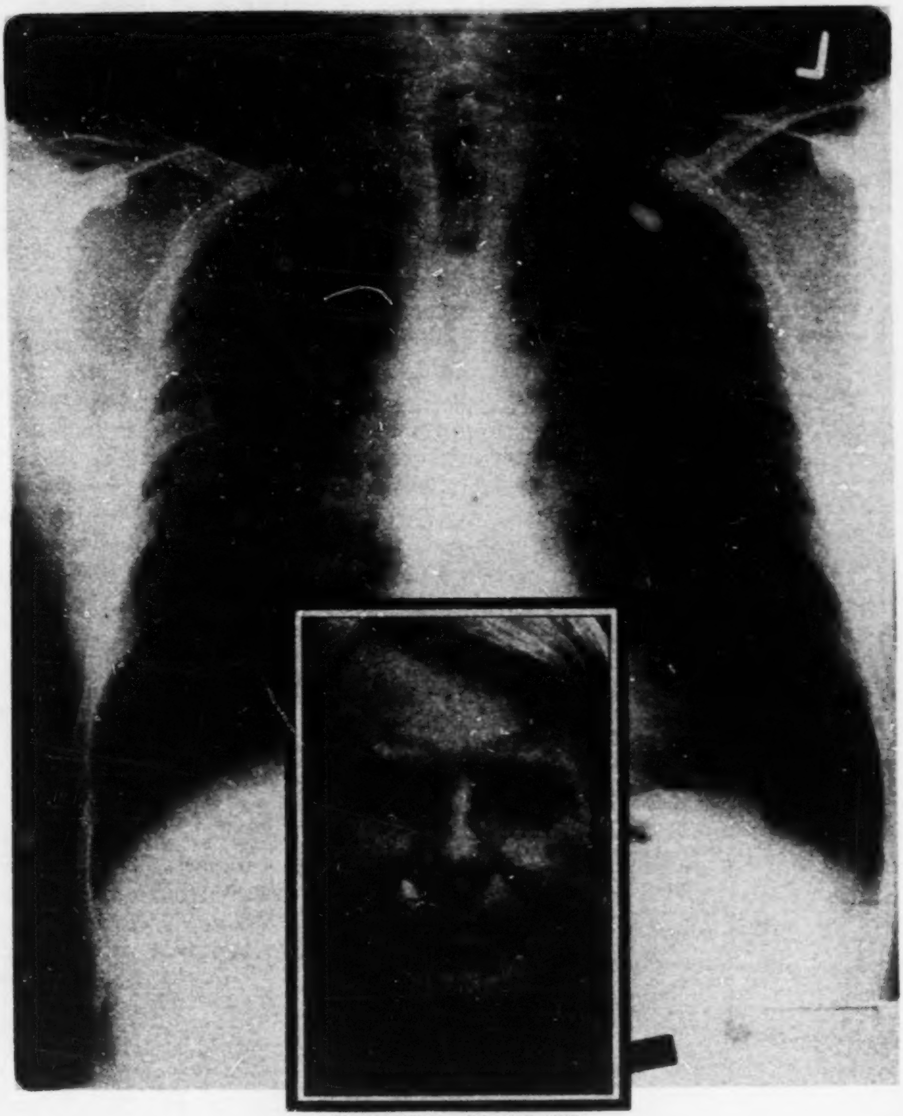
BY JOHN PEKKANEN

AN EDITOR'S NOTE

"Hope All Things, Endure All Things," the story of the life of Dr. Paul Adkins, brought forth a greater response from our readers than any other article *The Washingtonian* has ever published. It is the story of a good doctor, a man with a family and a future, who had to confront an illness he had treated all his professional life. It tells how a man of courage looked death in the eye, facing it without illusion, only occasionally flinching. It is a sad story, but also one of hope. Paul Adkins wanted the meaning of his life to live on. He leaves you a powerful message, one that the *Washingtonian* editors hope helps you to live a full life.

—John A. Limpert
Editor
The Washingtonian

WASHINGTONIAN



The chest X-ray of April 2, 1980: Thoracic surgeon Dr. Paul Adkins looked at it and saw a tumor in the right lung. (It is the egg-shaped whitish spot in the right lung—on the left of the X-ray in this view.) After treating thousands of lung cancers, he now was looking at the disease growing in himself.

HOPE ALL THINGS, ENDURE ALL THINGS

Dr. Paul Adkins Glanced at the Clock Above the Lightbox. It Was 3:10 PM on Wednesday, April 2, 1980. He Took a Final Look at His X-Rays and the Thought Hit Him: "I Am Looking at My Own Obituary."

BY JOHN PEKKANEN

The fatigue began in January. It was then that Dr. Paul Adkins first sensed that something might be wrong. He was 54, professor and chairman of surgery at the George Washington University medical school. A nationally recognized thoracic surgeon, he had been surrounded by illness for more than thirty years but had never been seriously ill himself.

In the beginning he tried to ignore the fatigue, to convince himself that it was caused by a combination of work and minor illness and would soon pass. But he couldn't ignore the disturbing fact that a man who had seldom needed more than seven hours of sleep a night, whose years of surgical residency had been marked by thirty- and forty-hour vigils, was now napping occasionally in the afternoon on his office sofa.

He was a man trained to logic and deduction, and he now was using that training to persuade himself not to become alarmed. But deep inside, down where the gut knows what the mind may deny, there were dark possibilities. It was not always easy to ignore them.

He recognized the irony. For his entire professional life he had diagnosed the sources of pain, the sounds of a chest, the rasp of a cough, the manifold murmurings of the human body. He had done this so many times for so many patients that he had long ago lost count. But now he was unwilling to focus this knowledge and experience on himself.

The fatigue persisted.

He realized that his history was against him. Although his body was still athletically trim, he had smoked cigarettes since he was fifteen. The habit intensified when he served as a surgeon in Army hospitals in Korea and Japan during the Korean War. He understood the implications of smoking up to a pack and a half a day for close to forty years as well as anyone in the country: He had removed some 2,000 cancerous lungs in surgery.

But there was so much happening that month that he was easily distracted from thinking about himself. It was in many respects the culmination of his career, because on January 22, in Atlanta, he was to deliver the presidential address of the Society of Thoracic Surgeons, the largest organization of its kind in the world.

It was the most important speech of his life and he labored over it, not only on the ideas but on the words. Although a man of science, he had harbored a love of language since childhood and could still recite reams of poetry by Keats, Shelley, and Milton that he'd learned forty years earlier in Rutland, Massachusetts, and later, after his family moved here, at St. John's High School. He would recite this poetry to close friends and family.

In his neighborhood on Kirkwood Drive in Bethesda—a tree-lined street of large, comfortable homes—he was the resident poet, always called upon to write funny poems or limericks for birthdays and anniversaries.

At the hospital he wore quite another face. There he was first and foremost a surgeon: decisive, hard-headed, willing to take greater risks than most. He was a man certain of himself and at the same time shy to an extreme.

The surgical residents he loved to teach called him "The Boss." Virtually all the younger residents were, in the words of a GW colleague, "scared as hell of him." He seldom abided small talk. His sarcasm could be biting and his glare intimidating. But those residents who progressed steadily in the residency program began to realize there was more to him than the stern face. By their third or fourth year they came to understand that at least part of their fear was misplaced. They understood that he jealously guarded his privacy and revealed little of his sensitivity or sense of humor to those he didn't know well. They came to realize that it was because he was lost in thought that he often walked down the corridors of the hospital oblivious to the people who said hello to him.

When he stopped to listen to someone, he was politely attentive, his look direct

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John Pekkanen—the health columnist of *The Washingtonian*—had many long conversations with Dr. Adkins and other principals of this story. He acknowledges the cooperation of all, particularly Dr. Adkins and family, who generously gave up many hours when every minute was precious.

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Dr. Paul Adkins and his wife Faith, with sons Paul and Bill, in the backyard of their Bethesda home on July 20, 1980. By then Dr. Adkins had a metastasis of the lung cancer on his upper lip and wore a small bandage to cover it.

and steady. In normal conversations, his voice had a midwestern flatness to it. His hair was flecked with gray and he favored conservative suits and ties. He liked simplicity. He had three loves: his family, his work, and golf.

The Atlanta speech drained him further. He thought fleetingly that if the persistent fatigue was a sign of something serious he didn't want to know it now. He'd rather go to Atlanta and give his speech without finding out.

"Accentuating the Positive" is what he titled his address. He had bandied about dozens of ideas with his wife before finally settling on it. The address traced the traditions and future of thoracic surgery and identified the problems it faced and offered ways to deal with them. Like many other significant moments in his professional life, it was one he shared with his family: Faith, his wife of more than thirty years, and three of his four sons, David, Mark, and Bill, went to Atlanta with him. Paul, his third son, a junior on the Bucknell basketball team, had a game to play and couldn't accompany them.

Dr. Adkins went to the round of cocktail parties, greeted many old friends, accepted congratulations for the speech. After their sons returned home, he and Faith stole away for five days with two old friends, Dr. and Mrs. George McGovern of Pittsburgh. Paul Adkins and George McGovern had known each other since their surgical residencies more than 25 years earlier. Now the two couples went to Ocean Reef on Key Largo, Florida, for sun and relaxation.

It was there that someone else noticed for the first time that Paul Adkins didn't appear to be well, didn't seem to have his usual drive.

"Why is Paul sleeping in the afternoon?" Dr. McGovern asked Faith Adkins. She said she wasn't sure but assumed it was because of his exhausting schedule recently: administrative chores at GW, surgical duties, teaching, medical rounds, speech-writing.

"It isn't like him," Dr. McGovern said.

Two weeks after Paul and Faith Adkins returned from Florida, he apparently came down with the flu. It was severe, but he was not alarmed by it; everyone caught the flu in February. Among the symptoms he experienced were nausea, fever, vomiting, and diarrhea. These passed after a few days. Coughing and fatigue persisted and Faith Adkins began to worry.

This fatigue was more bone-wearying than any he'd experienced before. It caused him to fall asleep soon after dinner, even though he had continued to nap in the afternoon. When he awoke in the morning he wanted to stay in bed, to get more sleep. It became difficult for him to go through routine surgery without feeling spent.

His cough was low and rumbling, as if coming from deep inside his chest. He tried syrups and antibiotics, but the cough persisted. Finally he became so concerned that he quit smoking. When he told people he had quit, he felt that special pride one experiences after breaking a bad habit. Friends were supportive, and colleagues who had often remarked on the irony of a chest surgeon who smoked congratulated him. No longer would the length of a GW faculty meeting be calculated by how many ashtrays he filled.

The cough eased but hung on for weeks. It was particularly bad at night. His second son, Mark—a senior at the GW medical school, who often rode back and forth to the hospital with him—became sufficiently alarmed to tell one of the doctors at GW about the nighttime coughing. Then he confronted his father about it.

Ever since Mark had switched from being a Spanish major at the University of North Carolina to enroll in the premed program there, father and son had played games of medical one-upmanship with each other. The father, ever the teacher, would ask the son questions, usually about his own specialty, and Mark would respond in kind, asking his father questions about another area of medicine, perhaps something he had studied recently in anatomy. It was a form of good-natured kidding, father and son each taking a pride in the other's knowledge, each delighting in stumping the other.

Now, toward the middle of March, Mark asked a more pointed question:

"Do you know what the primary cause of a cough like that is?"

"Yes," Dr. Adkins answered. "Bronchitis."

"No," Mark said. "Tumors."

"Bronchitis," Dr. Adkins repeated, more adamantly.

Mark let it pass. But a few days later at the dinner table he said to his father: "You ought to have an X-ray."

There was no response, so Mark tried again.

"Yeah," Dr. Adkins finally said. "I'd better."

For as long as Mark could remember, he and his brothers had teased their parents about smoking in a vain effort to get them to stop, and now that he had asked about the cough and need for an X-ray he sensed for the first time that perhaps his father was actually afraid of discovering the truth about his health.

Dr. Adkins began to feel worse. One day when he was playing golf at Burning Tree, his caddy, a cheerful man nicknamed Fishcake, remarked that he looked ill and should see a doctor. Dr. Adkins's usual ten-handicap game was badly off.

Faith Adkins was increasingly concerned. Toward the end of March the two of them drove to Charlottesville, where Dr. Adkins spoke at the University of Virginia Medical School. During the drive he promised his wife that he would get a checkup.

A new bout of nausea and vomiting now hit him, coupled with the fatigue and coughing, and he was forced to do something that no one could remember him doing before. He called in sick.

Cindy Fisk, his secretary for a dozen years, had seen him growing weaker. Concerned, she now asked him how ill he was.

"Just cigarette withdrawal," he said.

She was grateful he'd quit. She always felt awkward when patients asked why there were ashtrays in the office of a

Dr. Adkins took the X-rays out of the folder and put them on his own lightbox. "What do you think of these?" Dr. Adkins asked. Dr. Aaron replied, "It looks like a pretty bad cancer of the lung." "They're mine," Dr. Adkins said.

chest surgeon. She avoided saying they were for the chest surgeon himself.

Dr. Benjamin Aaron, head of cardiac surgery at GW, was also concerned about Dr. Adkins's health. Dr. Aaron's office was next to Adkins's on the eighth floor of the Burns Memorial Building, at 23rd and Pennsylvania, Northwest, just across 23rd Street from the hospital. A Navy doctor for 22 years, he had come to GW a few months earlier. Lately he had begun to notice that Paul Adkins, the man who had hired him, had changed. He had become irritable and his face seemed to be fuller, as if he had gained weight. It didn't look like healthy weight.

Why Paul Adkins refused for so long to get a chest X-ray when he passed the outpatient X-ray laboratory every working day was probably due to a mix of dread and optimism—a suspicion that something might be terribly wrong was delicately balanced with a rationalized hope that it was minor and would quickly pass. But finally, when the fatigue and coughing grew undeniably worse, when he felt so dragged out for so long that he wanted to find answers himself rather than put up with feeling so awful, he asked Cindy Fisk to call X-ray for an appointment. She arranged one the same afternoon. It had been nearly three years since his last one.

He operated that morning, removing a tumor from a chest. In the afternoon, he picked up the X-ray slip from Cindy and took the elevator down to the X-ray lab on the first floor of the Burns Building. Enjoying one of the perquisites of his status, he walked into the X-ray room without waiting after handing the order slip to the receptionist.

The X-rays—front and side—took only seconds. While he was buttoning his shirt he glanced up at the technician clipping his X-rays on the lightbox attached to the wall.

He stopped buttoning his shirt, his eyes riveted on the lightbox. He moved in for a closer look. In the upper lobe of his right lung there was a large, grayish spot, a shadow. It was irregular in shape, about the size of an egg. In the lateral view he saw string-like tentacles that reached down into his lung, as if grabbing at it. Looking further, he saw a wide shadow in the mediastinum, on both sides of the trachea, where the lymph nodes that drain the lung are located. On the left side he noticed another shadow, just above the aortic arch.

He glanced at the clock above the lightbox. It was 3:10 PM Wednesday, April 2, 1980, a time and date he would never forget. As he took a final look at the X-rays, the thought hit him: "I am looking at my own obituary."

With all the control he could muster he slipped the X-rays back into a large manila folder and quietly walked out of the X-ray suite. Back in his office he began to pace. His mind swirled. Perhaps he had read too much into the X-rays. Perhaps his imagination had gotten the better of him. He needed a second opinion.

He walked next door to the office of Ben Aaron, who was doing some paperwork. "I've got something I want you to see," Dr. Adkins said. "Can you come into my office?" Ben Aaron followed him there. Dr. Adkins took the X-rays out of the folder and put them on his own lightbox.

"What do you think of these?"

Dr. Aaron, who had performed general chest surgery for years, replied quickly: "It looks like a pretty bad cancer of the lung."

"They're mine," Paul Adkins said.

Dr. Aaron instinctively put a hand on Dr. Adkins's shoulder. They sat down and tried to regroup their thoughts. Both had diagnosed countless X-rays like these and realized what they had seen: cancer that was inoperable and terminal.

Dr. Aaron watched as Dr. Adkins began talking to himself and slamming his fist on his desk. "Damn," he kept repeating. His voice was anguished. To come this far, to reach this point, and now for this to happen.

Dr. Aaron tried to offer comfort. He would help in any way he could, he said. After Dr. Aaron left, Dr. Adkins began to pace again. Whenever he called patients into his office to give them news like what he'd just received, he tried to console them, to reassure them. He used words like "tumor" or "malignancy"—gentler words than "cancer"—because he wanted to soften the shock of such news as much as he could. But there was no reassuring doctor at hand to convince him that much could be done, that miracles happened. The news had hit him like a snake strike.

He wanted one more opinion—that of Dr. David Rockoff, head of diagnostic chest radiology at GW and an expert in

Dr. Paul Adkins (front row, center), chairman of surgery at the George Washington University Medical School, was photographed in 1978 with GW surgery residents. Students voted him the "Golden Apple" award as outstanding teaching professor in 1975. To the left of Dr. Adkins is Dr. Stephen Pett, and at the far right in the second row is Dr. John Walsh—both had special relationships with Dr. Adkins.

reading X-rays. Dr. Adkins headed over to the main hospital.

David Rockoff had known Paul Adkins professionally for more than ten years. They often consulted on cases, Dr. Rockoff as the diagnostician and Dr. Adkins as the surgeon. They had a good relationship, exchanging jokes, talking freely, respecting each other's skill.

Now, as Dr. Rockoff, an energetic man in his late forties, emerged from the room where he had been performing a lung biopsy, he was surprised to find Dr. Adkins waiting outside wearing a grim expression and holding a manila envelope. The chief of surgery usually does not wait for people; he leaves messages for them to contact him. There was something he wanted Rockoff to see, he said, and Dr. Rockoff read the urgency in his voice. He invited Dr. Adkins to his office, on the first floor of the hospital, and on the way there he was jarred a second time when he told a small joke and Dr. Adkins, usually one to enjoy a joke, failed to laugh, failed even to acknowledge it.

They went to Dr. Rockoff's office. "What do you have?" he asked Dr. Adkins. Without preamble Dr. Adkins opened the envelope and handed over the X-rays. Dr. Rockoff turned to his lightbox and began clipping them on. This time Dr. Adkins, sagging in a chair, his face ashen, dropped all pretense that they were looking at the X-rays of an anonymous patient.

"Dave," he said, "it's finally caught up with me."

Dr. Rockoff looked at the X-rays. When he spoke, there was pain in his voice. "I don't know what to say to you. Do you want me to tell you what I see or do you want me to call somebody else?"

"I want you to tell me."

Dr. Rockoff went over his findings in detail. The most ominous was the spread of cancer from the right lung to the left and the involvement of the lymph nodes. The left main-stem bronchus, an air passageway from the trachea to the lung, was severely constricted by the tumor. This was the cause of his coughing. Dr. Adkins forced himself to listen to every word.

Dr. Rockoff had no illusions about the eventual outcome of the disease, but right now he was more concerned with the state of his friend's mind; such devastating news could unhinge anyone. He asked Dr. Adkins if he had told his family. He was prepared to leave his office and drive Dr. Adkins home.

Dr. Adkins said he was going to call Charlie Thompson, whom he considered his primary physician, and try to see him today. Later he would go home and tell Faith face to face. Dr. Rockoff felt a little relieved. When Dr. Adkins moved to leave, Dr. Rockoff patted him on the back and wished him well. The X-rays were left behind.

Dr. Paul Adkins in surgery: He was the president of the American Society of Thoracic Surgeons and he'd removed some 2,000 cancerous lungs, but he still couldn't bring himself to give up smoking.

Dr. Rockoff closed the thick oak door to his office, sat down, and looked at the X-rays one more time.

Their message was still plain. Paul Adkins would be lucky to be alive on Labor Day.

Charles Waters Thompson stands a shade under six feet tall, has a round, owlish face and a fringe of gray hair, and at 65 still strides with the erect carriage and talks with the bark of a Marine drill instructor. To say that his demeanor is crusty and his language salty is to say a Rolls-Royce is an expensive car. He is not above answering his office telephone thus: "Who the hell is this?"

He is an internist in private practice and has been a clinical professor of medicine at GW for more than thirty years. His father and grandfather also were associated with GW. There has been a Dr. Charles Thompson at GW since before the Civil War. This one will be the last.

Beneath the tough exterior is a sensitive and vulnerable man, unafraid to cry and unafraid to feel deeply for his patients, to make their cause his cause. He is a physician in the old tradition of healer and comforter. He will accept no obstacles that interfere with the welfare of his patients and he raises hell with anyone or anything that does. "If you do your job, sometimes you have to be a son of a bitch," he is fond of saying.

Once he was informed that a staff dermatologist was unwilling to come over from his office to see one of his patients at the hospital because it was getting late in the afternoon and he wanted to go home. Dr. Thompson picked up the telephone, called dermatology, and told whoever answered that people didn't get sick according to eight-hour workdays and it would be a very good idea if the dermatologist got his ass over here to see his patient. Immediately. The dermatologist showed up in five minutes.

He's not certain why he is what he is—why he speaks out so forcefully when others are often silent—but he thinks World War II had a lot to do with it. He was in the thick of the war during some of its fiercest fighting. A medical officer with the amphibious forces off the coast of Italy and, in 1943, in Salerno, he was awarded the Bronze Star for meritorious service under fire. That wartime experience, and a stint in Japan just after hostilities ended when he attended to prisoners of war, changed him in ways nothing else could. He saw too many people wounded and killed to accept complacency or to think that his mission in life was to do anything other than tend to people who needed him.

Late in the afternoon of April 2, he was not surprised when he received a call from Paul Adkins. They had known and liked each other since the 1950s. Although their styles differed, they got on well because they shared the same values in medicine: They both cared about teaching and their patients. Over the years Dr. Thompson had referred many of his patients to Dr. Adkins for surgery and had treated members of the Adkins family—including Paul Adkins occasionally. The day before, Paul had called to say he wasn't feeling well, and Dr. Thompson had urged him to come in for a checkup. When talk of an X-ray came up, Dr. Adkins said he was planning to

Paul threw his arms around her and held her tightly and told her the news without adornment, just as he'd gotten it. She knew he had been ill, but nothing had prepared her for this.

have one. Now he was calling to say he'd just had it.

"What does it show?" Dr. Thompson asked.

Paul Adkins answered: "I've got bilateral inoperable carcinoma of the lung."

"Come over right now," Dr. Thompson said.

Within minutes Dr. Adkins appeared at his door. Dr. Adkins sat down in a chair across from Dr. Thompson's desk and they began to talk. It was not so much a conversation about medicine as about the full range of consequences of the X-rays. Dr. Adkins remonstrated with himself for smoking, for not quitting twenty years earlier. At the same time he took some comfort in the fact that his house was paid for and his four sons pretty well launched. David, 29, the eldest, was a stockbroker here; Mark, 26, was in GW medical school; Paul, 21, was a junior at Bucknell; and Bill, 17, was a junior at the Landon School.

Charlie Thompson realized that his medical expertise was essential but that right now something else was needed. He began to open the door, ever so slightly, to the possibility of hope, to the need to fight back. Perhaps there had been no further spread, he said; they needed nuclear scans to determine that. Dr. Thompson palpated his neck and found no spread to the neck's lymph nodes, an encouraging sign. Soon Paul Adkins was speaking optimistically. Although Dr. Thompson never said that there was a way out, he encouraged his optimism.

Finally Dr. Thompson asked him who he wanted to take care of him.

"I want you to," he said. He was unequivocal. He knew how hard Charlie Thompson fought for his patients.

Dr. Adkins agreed when Dr. Thompson said that if he was in charge he would have to be in charge of everything, be the clearing point for all the medical treatments and tests that Dr. Adkins would undergo with specialists who might eventually be involved in the case. When he was a young physician Dr. Thompson had learned a bitter lesson. He had seen the eighteen-year-old daughter of a prominent doctor die needlessly because each of four specialists thought another had given her a vital medication. None had.

He would make certain nothing like that would happen in this case.

Faith and Paul had met in high school. Her best friend—a classmate at the Academy of Holy Names, an all-girls' school in Silver Spring—first pointed him out to her. He was tall, handsome, terribly shy, on the football and basketball teams and the colonel of the cadet corps at St. John's High School. He was also an exceptional student. (He ended up graduating first in his class, but when asked in later years how he had done academically he would simply say, "Pretty well.") She was attractive, delicate, and dark-haired, and had a quick intelligence.

He lived in the District and she in Silver Spring, but their homes were only six blocks apart. At the urging of her friend she boldly went up to him one day and asked if he would like to escort her to her high school dance. He smiled and accepted.

Their relationship was slow to kindle despite the mutual attraction of this young boy and girl, both from middle-class homes, both strong Catholics. After high school he went off to Johns Hopkins, where he'd been awarded a scholarship, where he played football and basketball and earned high academic honors. Faith stayed in DC to attend Trinity College, where she majored in biology.

He turned to premed for no other reason than it sounded interesting. It was only after he became exposed to the mysteries of the human body and to the ways medicine could intervene to cure disease that he became certain he wanted to pursue a medical career. Surgery especially appealed to him because it was so direct, so clean in curing disease.

They corresponded while he was an undergraduate at Hopkins—on an accelerated wartime program that included summer school—and later while he studied at the school of medicine there. On rare weekends when he came home, they went out. After college she began work as a biologist at NIH, participating in early chemotherapy experiments on mice.

They were married in 1949 when he was doing his general-surgery residency at Hopkins and being paid all of $16.66 a month, which was supplemented by her wages from the Marine Hospital in Baltimore, where she had asked to be transferred. He also supplemented their income by selling his blood at $25 a pint. Their phone was plugged into the hospital switchboard and their life in those early years was punctuated by his being summoned at all hours to go to the hospital.

Their first son, David, was born in 1951 while his father was serving in the Army Medical Corps in the Far East, and when Dr. Adkins was discharged in 1952 the family returned to Washington. While in the Army he had become aware that few surgeons seemed to know much about chest surgery. He wanted it to be his specialty.

He entered the thoracic-surgery residency program at GW and they moved into an apartment in Park Fairfax. They had little money, but they did have a stylish old Buick convertible. She gave up her own career and settled in to becoming a wife and mother, spending her spare time tending her garden and playing the piano. Later, because he loved it so much and they wanted to be together more, she took up golf.

Their marriage underwent the stresses all marriages do. He was away often and there were the normal problems of raising four very robust and individualistic sons. But they shared an abiding affection for each other and their sons. They traveled together as often as they could, entertained close friends, attended the Little Flower Church every Sunday after moving to Bethesda in 1959. And every day of their life together he would say to her, "Have I told you today how much I love you?" She never tired of hearing it.

Faith Adkins was surprised that Wednesday afternoon when she saw her husband's blue Cutlass speed up Kirkwood Drive and turn quickly into their driveway. It was only 4:55, and he usually arrived home around 6:30 or 7. She noticed that he appeared to be hurrying as he came up the steps.

He threw his arms around her and held her tightly and told her the news without adornment, just as he'd gotten it. She knew he had been ill, but nothing had prepared her for this.

They walked to the den and talked, and from that moment on Faith Adkins, a woman of unusual strength and character, never had any illusions about what would happen to her husband. She had too often heard the words "inoperable carcinoma of the lung" to allow any false hope to creep into her thoughts.

She wept and realized that from now on he would need her as he had never needed her before.

All the Adkins children were told of their father's illness immediately, except Mark, who was in New York City trying to find an apartment. He had been accepted into the prestigious surgical residency program at New York University and was due to report there July 1.

When Mark returned home the following night he was exhausted and depressed from seeking the next-to-impossible—an affordable, comfortable apartment in New York City.

He began complaining as soon as he got home. He walked into his parents' room and was letting off steam when his father quietly said to him: "Mark, I've got some bad news."

He told his father that no news was as bad as the news he'd just gotten in New York. Dr. Adkins interrupted to tell him he'd had a chest X-ray that showed a lesion in his upper right lung.

What kind of lesion?

His father began to tick off the possibilities, all of them extremely remote except one: lung cancer.

The next morning Mark went to his father's office. It was small and spare. Framed diplomas hung behind his desk, and pictures of himself with some of his closest friends—thoracic surgeons from all over the country—hung in the short hall outside. Once, when someone remarked on the small size of his office considering the position he held at GW, he said if he were really efficient he wouldn't even need a desk.

Mark visited there often to read Dr. Adkins's medical texts. As he sat there this morning his father came in and silently took his customary seat behind the desk. They said very little to each other. Both by nature were quiet and thoughtful. They often spent the time driving to and from the hospital in silence.

Mark now moved from the sofa and sat in the chair directly in front of his father's desk. "What you told me last night really upset me," he said. "Tell me it's a bad dream I had."

His father answered softly: "I wish I could."

The weekend following his X-ray Dr. Adkins noticed that he couldn't button his size-fifteen collar. His neck had enlarged and his face was obviously fuller and rounder when he looked at it in the mirror. He diagnosed himself: He had vena caval obstruction.

The vena cava is the major vein carrying blood back to the heart. The tumor was pinching it, closing it off so all the blood could not return, causing the swelling in his neck and face. He was alarmed at how quickly it had happened, and alarmed at what it might mean.

He had scheduled himself to be admitted at GW on Monday, April 7, for the biopsy, and now treatment would have to include the vena-cava problem. In all likelihood radiation therapy could reduce the obstruction.

On Monday morning, the day after Easter, a cloudy day threatening rain, Dr. Adkins went to the hospital just as he had done every other workday for the past thirty years. But this time he went as a patient.

Mark Adkins, on general-surgery duty on the sixth floor, watched at a distance as his father, carrying suitcase and wearing street clothes, walked toward his room. His head and neck were swollen further.

"What you told me last night really upset me," Mark said to his father. "Tell me it's a bad dream I had."

Mark felt very uneasy about watching his father admit himself to the thoracic-surgery wing he had dominated for ten years as chairman of surgery. Dr. Adkins felt no such uneasiness, because he liked and trusted the people he'd hired.

The vena-cava problem introduced a new serious risk. General anesthesia, ordinarily used during biopsies, causes swelling of the brain. In Dr. Adkins's case, there already had been considerable swelling, so the use of general anesthesia posed a risk of permanent brain injury.

Dr. Adkins had asked Ben Aaron to perform the biopsy—to go into the chest if necessary—to get a slice of tissue so pathology could determine if it was malignant and pinpoint its cell type.

Because of the high risk of anesthesia, Dr. Aaron began palpating the neck. No enlargement of the lymph nodes had been detected by Charlie Thompson five days earlier, but now Aaron found some. This was an encouraging sign for surgery because it meant they could just take a slice out of the node and not open the chest, thereby avoiding general anesthesia, but Aaron recognized it was a bad sign for Dr. Adkins's prognosis. For a node to have enlarged to such an extent meant the cancer was spreading fast.

The biopsy was scheduled for Tuesday, April 8, and the operating-room supervisor closed off all the windows to keep away onlookers. The word of Dr Adkins's illness had swept through GW like a grass fire.

Dr. Adkins was tranquilized but conscious as Dr. Aaron began his cut near the collarbone. They exchanged few words. Dr. Aaron wanted to make certain he was causing only minimal pain, and Dr. Adkins assured him he felt very little.

Dr. Aaron cut into a nest of lymph nodes and found an ominously large one. The node was firm and whitish, surrounded by supporting tissue and apparently without blood vessels. It bulged when Aaron cut into it to get a slice. Dr. Aaron knew immediately that he was cutting into a malignancy. "Anything that looks like that and cuts like that, in that region of the body, is cancer," he said later.

The biopsy took thirty minutes. A few minutes later the preliminary report from pathology came back. It was an anaplastic carcinoma. Cancer.

Mark Adkins had waited outside the operating room. When the biopsy was over he followed his father down to the recovery room and they spoke briefly. Mark asked him how he was and he said pretty well, that it had been fairly easy.

Moments later Mark met Dr. Aaron in the hall outside the operating room and they walked to a nearby alcove, sat down, and talked. Mark had held out hope, against all reason, that it might not be malignant. Now he asked Dr. Aaron how long his father had. He hoped for five years—that was a figure he'd often heard associated with cancer survival. Aaron told him that, in his experience, people with this disease in this stage lived for only a few months.

Mark thanked him for his candor and went back to work.

Paul Adkins once confided to a friend that he never intended to intimidate his residents and other members of the hospital staff, that this was simply a result of his personality.

Sometimes, usually after a series of incidents rather than a single incident, his temper could get the best of him. He once hurled a ballpoint pen across his office and a young medical resident had to duck to avoid it. He wasn't aiming at the resident; he wasn't even mad at him.

Notwithstanding the reputation he had earned as an unyielding taskmaster—especially when it came to surgery—the single most difficult thing he had to do as chairman of surgery was to fire people. He did it only three times in the ten years he was chairman, and each firing was painful for him.

He realized that many people wrongly imagined him to be cold and aloof. He didn't see much he could do to change that. He wasn't a backslapper or a charmer; he had to say what he thought, and he would not put up a pleasant facade to persuade people otherwise.

He was extremely sensitive to personal slights. They could darken his mood and cause him to withdraw and become silent. He took things very personally, and he couldn't change that, either. The hard outer shell was there because his profession demanded it. You don't train Marines or young doctors effectively by being kind.

But he was a strongly ethical man who cared about each of his patients. When he was still performing cardiac surgery in the early 1960s he received a call from the local chapter of the American Heart Association, asking him to suggest the name of a young patient, someone who could be shown off at a fundraising dinner. Dr. Adkins gave them the name of an eleven-year-old girl whom he had surgically cured of a complex heart defect. The heart association was pleased until they learned the girl was black. Thanks anyway, they said, we'll find someone else. Dr. Adkins vowed at that point never again to have anything to do with the heart association, and he didn't.

And there were many moments when he was extremely kind. Three years earlier Dr. Stephen Pett, a young GW surgeon trained by Dr. Adkins, lost his first patient on the operating table.

The patient, a man admitted late at night with an aortic aneurysm, hemorrhaged. Try as he might, Steve Pett could not stem the bleeding from the large, pulsating artery fast enough to save him.

In the stark operating room, at midnight, as he was pronouncing the man dead, Dr. Pett looked up to see Dr. Adkins, who had been summoned from his home. Steve Pett was in a mood of self-recrimination, feeling a desperate sense of failure. Dr. Adkins walked over to him and spoke quietly, reassuringly, telling him that he hadn't failed, that in the business of surgery, deaths must be expected and that hemorrhagic death was always lurking in the operating room.

Dr. Adkins then suggested they go on rounds, to get Steve's mind off what had happened, and to remind him of the patients now recovering, the patients they'd helped.

This was a tender side that Dr. Adkins seldom displayed. So in his hospital room that night, only a few hours after the biopsy confirmed what he already knew, he was overwhelmed with the number of visitors. They came from all over the hospital: orderlies, nurses, residents, friends, other faculty. They all came to cheer him up, to wish him well, to tell him they were thinking about him and were pulling for him.

Several of his surgical residents brought a bottle of Johnnie Walker scotch and poured drinks all around. Old stories were told, jokes exchanged.

He finally grew exhausted, but he had been moved and touched.

His melancholy began to ease. He hadn't realized that so many people had so much affection for him.

During his five-day hospital stay in April, two encouraging medical findings allowed Dr. Paul Adkins to begin to hope again. The bone, liver, and head scans, during which radioactive isotopes are injected into the vein and reveal metastatic disease, indicated that there was no further spread of the tumor to other sites in his body. The brain, a likely place for lung cancer to spread to, was a special concern. But no cancer was detected there. Dr. Thompson, who visited him at least once a day, continued to encourage hope in his patient.

He had known the risks of smoking but gambled on genetics. His parents were both heavy smokers and long-lived.

Dr. Adkins knew cancer could spread through the lymphatic system or the blood stream or through both. He realized there was already lymphatic spread but he was encouraged—more so than his condition warranted—that his blood stream had not spread the malignancy in any detectable way. If it spread in the blood stream, he knew his time would be very short.

He was encouraged further when radiation therapy to his chest region—begun the same day as his biopsy—reduced the tumor enough to eliminate the vena caval obstruction. His neck—at one point two inches larger than normal—and his face both returned to normal size. The radiation therapy would be continued for two weeks, be stopped, be resumed again in May, and be completed in June.

A more detailed pathology report now indicated that he had large-cell anaplastic carcinoma of apparent glandular origin, a type of lung cancer often associated with cigarette smoking. The information might be useful should he ever undergo chemotherapy, a prospect he was considering—and dreading. He had never had any doubt that smoking was the cause of his cancer. He was conversant with the theory of how it occurs—an irritation of the lung cells, caused by elements in the cigarette smoke, in turn causes one of the cells to slowly transform into a malignant cell, which keeps dividing and redividing until it has created a tumor mass.

He had known the risks of smoking but gambled on genetics. Both his parents had been heavy smokers. His father lived into his late eighties before dying of a disease unrelated to smoking. His mother, now in her early nineties and somewhat senile, was at a Bethesda nursing home—still, he said, "smoking like a chimney." He brought her a carton of cigarettes when he visited her every week or two. He had not spoken to her of his disease, nor would he.

He told his family when they visited him in the hospital that week that he was encouraged, that things could be a lot worse, that he might beat it. He was also feeling stronger. For the first few days after the initial X-rays he had been obsessed with his disease every waking moment. Now he detected a small change. He found himself able to think about other things; no longer did he lie awake in bed all night berating himself for his failure to stop smoking years earlier. Always disciplined, he had willed himself to overcome such feelings of self-pity and recrimination and to live from day to day. It was all he could do.

Nor did he mentally thrash himself for not having had a chest X-ray sooner, back when the first signs indicated that all was not well. He knew what all experts in lung cancer know, that by the time there are symptoms of the disease it is usually too late to stop its spread. He also knew that ninety percent of the people who are diagnosed as having inoperable lung cancer are dead within six months. Ten percent live as much as sixteen months longer. He chose to put himself in with the ten percent.

He was the only doctor who did.

Physicians in the upper echelons of their specialty are part of an elite national network, and they are often in contact with colleagues around the country to exchange information. It was not long before word of Dr. Adkins's disease spread among his colleagues. Only a few days after he was released from GW Hospital, while he recuperated at home, he received a call from Dr. Edward Beattie, the chief of thoracic surgery at Sloan-Kettering Memorial Hospital for Cancer and Allied Diseases in Manhattan.

Of all the institutions in the country involved in cancer treatment, Memorial offers the most radical procedures. (Often it is up against incurable cancers.) Severe and even mutilating surgery and extremely high doses of chemotherapy are often attempted in the hope of extending life. Sometimes life is extended. But the quality of the extended life is a major point of contention. Is there any benefit to extending life of a terminal cancer patient three or six months if he or she is in terrible pain, unable to get out of bed, unable to comprehend what is happening?

Dr. Beattie knew of Dr. Adkins's illness and, being an old associate, offered his condolences and then offered his expertise if Dr. Adkins would come up to Memorial immediately. By this time Dr. Adkins had begun to feel a little stronger. He had just gotten over his first bout of nausea, a side effect of his radiation therapy and perhaps of his disease as well. He said that he was planning to go to San Francisco for the annual meeting of the American Association for Thoracic Surgery and suggested they meet out there.

Dr. Adkins went to San Francisco—the meeting was held from April 28 to April 30—primarily to prove to himself that he could live a normal life. Mrs. Adkins accompanied him. They discovered that virtually everyone there knew of his illness.

Several physician friends offered to help Dr. Adkins in any way they could, and Dr. Beattie was the most insistent. Dr. Adkins promised to let him examine his case.

The next week Dr. Beattie telephoned Dr. Adkins in Washington and implored him to come to New York immediately so specialists at Memorial could examine him and determine what they could do. It was a Wednesday and Dr. Adkins, who felt he was being pressured in a friendly but persistent manner, said he would be unable to come up immediately but he could make it on Saturday. He agreed to send his X-rays up beforehand.

In early May Dr. Adkins had started to become increasingly short-tempered; he seemed to become annoyed over minor incidents. The anger seemed general, not aimed at anyone or anything but rather at his fate.

On the day Dr. Beattie called, Dr. Adkins seemed especially irritable. Later that morning he called out to Cindy Fisk, his secretary, to find out if she had collected his X-rays to mail to Memorial and to another physician friend, Dr. Cliff Mountain, at M.D. Anderson Hospital in Houston. She had spent much of the morning collecting and packing the films and she had them ready. She knew he was irritable. She told him she was just about to go out and mail them.

"I'll be dead before you get this done," he yelled.

On Friday afternoon, the day before he was scheduled to go to Memorial, he underwent a CT (computerized tomography) scan, a cross-sectional X-ray picture of the body. It showed the precise size, depth, and location of his tumor.

It was late in the day, nearing six o'clock, by the time the scans were finished. As Dr. David Rockoff examined them he noticed the left main stem bronchus was now showing signs of being squeezed even more by the tumor. He remembered the time Dr. Adkins had come to his office with the original X-ray. He had wanted to know every detail then, every observation Dr. Rockoff could make about his case.

Now Dr. Adkins stood silently putting on his tie in a corner of the scan room as Dr. Rockoff studied the X-ray images on the computer visual display console.

It was obvious to Dr. Rockoff that Dr. Adkins no longer wanted to look clinically at his own case.

"Paul," he called, "you're welcome to come over here and look at these."

Dr. Adkins said, "No, I'll just stand here."

It was obvious to Dr. Rockoff that Paul Adkins no longer wanted to look at his own case clinically. He was compelled to pull back from this knowledge if he was to have any chance at all of hope.

Dr. Rockoff realized his role wasn't to give false hope, but he knew it wasn't to destroy hope, either. If Paul ever wants to know, he thought, he will ask.

"Here they are," he said as he handed Dr. Adkins the envelope with the copies of the CT scans. "Good luck in New York."

Paul and Faith Adkins took the Eastern shuttle to New York on a bright, sunny Saturday morning in early May and met with Dr. Beattie and his staff. The X-rays and CT scans were examined and the options were outlined. They would start him on a regimen of very high doses of chemotherapy, a combination of cisplatinum, adriamycin, and vindesine. They explained the likely side effects. Mrs. Adkins became horrified at the thought of them—prolonged nausea, hair loss, extreme weakness, and no guarantee of a cure.

Dr. Beattie wanted to operate on Dr. Adkins, to perform a thoracotomy, which would involve opening the whole chest. Dr. Beattie proposed to enter from the back and "debulk" the tumor, a process in which as much of the tumor as possible is surgically removed. He then proposed to implant radioactive pellets that would continue to irradiate the tumors from within.

The prospect was frightening. The combined effects of the chemotherapy and surgery would devastate him. If it had offered even a forty-percent chance of two or three more years he would have taken it. But it did not, and he knew it did not.

The doctors at Memorial were insistent. They claimed that they had achieved an average remission time of twenty months. But Dr. Adkins didn't like the surgical approach to thoracotomy at Memorial. Why cut from the back, as they proposed, rather than perform a sternal split, which would give far greater access to the mid-portion of the chest, as well as to the right and left lung? He realized if he agreed to the operation he would never presume to tell them how to do it, but all in all he didn't think their surgical approach was sound.

He told them he'd think about it.

He discussed it with his wife, Dr. Thompson, and a number of colleagues at GW and at other medical centers around the country. The surgery was highly controversial, as was the implantation of the radon seeds. Their radioactive emission was uncertain so it would be difficult to determine how successfully the tumor was being irradiated. Mrs. Adkins thought the treatment at Memorial would be too much for her husband.

He also talked with Dr. Ben Aaron about it. Dr. Aaron echoed the advice of many other doctors. The procedure would make him sick and miserable, and he didn't think Dr. Adkins deserved that. Nor did Dr. Cliff Mountain of M.D. Anderson Hospital, who had carefully examined Dr. Adkins's X-rays.

Dr. Adkins and Dr. Thompson talked about advantages and disadvantages of staying at GW, and finally Dr. Adkins decided to remain. He would be treated there despite any difficulties that decision might create, and he wouldn't try anything exotic or experimental. He'd take the same treatment he'd recommend to any patient: He'd stick with straight radiation therapy—take it to the limit of 6,000 rads—and if his condition ever warranted it (and the specter of this scared him more and more), he would take chemotherapy. But for now there was no detectable metastases to other parts of his body, and he took solace in that. He would remain where he was comfortable, among people he trusted, and take it a day at a time.

Friends urged him to take a vacation—go to Tahiti, Paris, wherever. But he had no wish to leave. Being away from home and all that was familiar to him would only focus his mind on his disease. He didn't want that. He wanted to keep working, to maintain his routine as much as he could, to live a life as normal as possible. He asked a longtime fellow surgeon, Dr. Neofytos (Newt) Tsangaris, to be an associate chairman and to help him with administrative chores. Dr. Tsangaris, a large, friendly man, agreed. Dr. Adkins had no intention of relinquishing his duties altogether. He would continue to come to his office every day. That was where he wanted to be.

Some physicians make their mark by developing a surgical technique, some by curing a disease, some by self-promotion. Paul Adkins's reputation was made in no small part by the many reforms he brought to the board examination process in thoracic surgery and by the scores of young doctors he sent out into the world. He saw to it that these doctors understood how and when to operate, how to take care of patients.

Training young doctors for surgery is among the most delicate of tasks. A line must be carefully drawn so they can learn by experience while at the same time the welfare of their patients is protected. Dr. Adkins's technique was to allow young surgeons as much latitude as possible, allow them to learn by experience, and then, after they'd struggled through a procedure, show them how it should be done. "Neat but not gaudy," he'd remark after an especially elegant surgical procedure. Students voted him the "Golden Apple" award as outstanding teaching professor in 1975.

He stressed ethics to such an extent that his residents would never tell him when they were invited out to lunch by a salesman from a drug company. They knew he would consider it bad form, an unholy mixing of private interest with medicine. He refused to allow any representatives of commercial medical firms or physicians they sponsored to speak at "Grand Rounds," the lecture series held at all teaching hospitals. He would rather have paid for his own speaker than have a commercial firm provide one for free.

He could at any time in his career have left academic medicine, moved into private practice, and probably quadrupled his income. Although he earned a good salary, he was supporting a large family, sending or having sent four sons through private school and college, and the financial temptations were always present. He never gave them a second thought. He was a man satisfied to be what and where he was, and the fact that he earned considerably less than he could have was more than compensated for by his satisfaction in the quality people his training program turned out.

Of the scores of young physicians he trained over the years, Dr. Robert Corso was one of the few for whom Dr. Adkins foresaw eventual stardom. Bright, thoughtful, academically sound, and gifted in surgery, Dr. Corso had everything needed to achieve a brilliant career in academic medicine. They first met in 1964 when Corso was a first-year GW medical student. He selected Dr. Adkins as his faculty adviser.

From early in their relationship Corso was able to lift Dr. Adkins's veil, to see that this man who intimidated so many students and residents was sensitive, compassionate, shy. He greatly admired Dr. Adkins's mind, which he found eminently logical and penetrating. Other residents, noting the rapport, would ask Dr. Corso, who also spent his surgical residency at GW, to act as mediator with the boss.

"Neat but not gaudy," Dr. Adkins would remark after an especially elegant surgical procedure.

Dr. Adkins guided Dr. Corso toward the paths of recognition in academic medicine. He urged him to publish and pointed out the medical journals where he should place his work. Their relationship became almost father-son. Theirs was a friendship that promised to endure for life.

But after he finished his thoracic-surgery residency, Dr. Corso steadily grew disillusioned with academic medicine and with the limited opportunities he foresaw at GW for his major interest—heart surgery. In early 1977 he decided to leave academic medicine. He knew the break with his mentor would be hard, that Dr. Adkins would take it personally, that no amount of explaining would ease the pain.

It took him three weeks to work up the nerve to tell Dr. Adkins that after all these years together he was leaving, had already accepted a position as cardiac surgeon at the Washington Hospital Center. When Dr. Corso finally broke it to him, in March 1977, Dr. Adkins was silent, but that night he went home and, for one of the few times in his adult life, wept.

Their relationship was never again what it had been, but over the next months they spoke, often warmly, and once at a convention they went out for a drink and Dr. Adkins told him he was welcome at GW if he ever wanted to give academic medicine a try again.

Dr. Corso was pleased but refused. He had found in the practice of heart surgery something that excited him too much to leave it for anything else.

Last spring Dr. Corso was driving near his Bethesda home in his new sports car when out of the corner of his eye he saw Dr. Adkins's car backing out of the parking area at Burning Tree. He pulled up next to his old boss's car and waved. Dr. Adkins smiled weakly. Because he was dressed in his driving hat and goggles Dr. Corso thought Dr. Adkins didn't recognize him. He took them off and said, "It's me."

There was no snappy remark, nothing like "Why the hell are you spending all your money on a car like that?" Just that same weak smile as Dr. Adkins backed out and drove away.

Dr. Corso knew something was wrong. That night a resident called him and told him Dr. Adkins had just had an X-ray taken.

Dr. Corso telephoned Dr. Adkins and asked if he would like to talk.

They met in Dr. Adkins's office in the late spring. Each drank a glass of scotch and they talked easily. Dr. Adkins spoke of his disease, what he planned to do, how he was facing it.

Dr. Corso asked him if he wanted any help near the end if the pain became unbearable. Dr. Corso said if nobody else would put him out of his misery, he would be willing to perform this final gesture of friendship. He would have him admitted wherever necessary in order to do this.

Dr. Adkins thanked him but said he couldn't do that. His religion prevented it.

They parted as friends.

Later that summer another friend asked Dr. Adkins about suicide. PBS television had just run a show about a woman named Jo Roman, who, after she was diagnosed as having breast cancer, decided to kill herself rather than face the consequences of the disease and treatment.

"How could she do that?" Dr. Adkins asked the friend. "Why would anyone want to do that?" He'd taken care of hundreds of terminal patients and he could remember only one, a man with lung cancer, who actually killed himself.

"I don't consider suicide a viable choice," he said.

Toward the end of May Dr. Adkins was still feeling some effects of the nausea induced by his radiation therapy. The nausea was apparently brought on when malignant and normal cells were broken down by the high doses of radiation and released toxins. The extensive cellular damage also brought on fatigue. But all in all he felt he was picking up a bit, felt he had a reasonable amount of stamina. He remarked that now that he knew how debilitating radiation therapy could be, he would never again blithely recommend it to his patients. Some had told him how badly it made them feel but he had never fully appreciated that. He'd listened to them but never really heard.

His weight loss had by now become noticeable. He was down from his customary 172 pounds to around 150. Even though his nausea was not acute, he had little appetite. The cancer was compounding the weight loss because of the very high metabolic rate of malignant cells. His clothes began to hang on him. He hated it when people told him he looked good. He knew he didn't.

On May 23 his son Mark was to be graduated from the GW medical school. It was the culmination of a long ordeal for Mark, the first big hurdle in his medical education, and the fulfillment of an unspoken wish of his father. Dr. Adkins had never pressured any of his sons to go into medicine or any other field. He took enormous pride in all of them. On many Saturday mornings at the hospital, when the pace was slower than usual, he would look at the sports pages with his residents and read about the exploits of his sons, all of whom were athletes at Landon School. David, Mark, and Paul were quarterbacks. Paul, now at Bucknell, won the Touchdown Club's 1977 "Timmie" award as the prep football player of the year here. Bill, now a senior at Landon, is the biggest of the sons and a defensive lineman on the football team.

The GW graduation ceremonies were held in Lisner Auditorium on a sunny, warm Friday afternoon. Dr. Adkins had begun to appreciate little things much more since he had learned of his illness: good weather, bright flowers, the sound of a soft breeze, a pleasant dinner. Once taken for granted, they now were savored.

"Mark Adkins" was the first name in the graduating class, and when it was called Dr. Adkins, sitting on the stage dressed in academic cap and gown, burst into a luminous and proud smile. Mark walked to the podium and accepted his diploma.

When Dr. Adkins marched out in the academic procession at the end of the ceremonies he noticed a familiar figure standing quietly near the aisle. It was Dr. Milton (Bud) Gusack, his old and trusted medical colleague. They went all the way back to Johns Hopkins, where they were both in medical training during the 1940s.

Dr. Adkins knew why Bud Gusack was there and why he was beaming. His son, also named Mark, was graduating today as well. Dr. Adkins edged toward him and extended his hand. They shook warmly while the procession waited.

"Congratulations, Bud," Dr. Adkins said as they embraced.

Bud Gusack tried to answer but he was too moved to speak.

By early June, although his appetite was still slack and his energy diminished, Dr. Adkins felt more optimistic that he would fall into the lucky ten percent, that he might live a reasonably normal life for at least another year, perhaps longer. He played golf on weekends and fulfilled many of his duties at the hospital, including some surgery.

On a Monday in early June, walking out of a meeting, his spirits high, he approached David Rockoff.

"Dave," he asked, "did you know that radiation therapy is good for golf?"

Dr. Rockoff smiled and asked what he meant.

The promise of early July grew in his mind until he was virtually consumed by it. He wanted "to have one more good summer."

He told him that at Burning Tree the day before he'd shot a 76.

Dr. Adkins now began a new experimental treatment called thymosin, which had been co-discovered by Dr. Allan Goldstein, a University of Texas biochemist now teaching at GW. Thymosin was designed as an immunity enhancer and was believed to have potential benefits for cancer patients because both the disease and the radiation and chemotherapy treatments diminish the body's immune response. Thymosin might help in fighting the cancer as well as other infections.

The irony was that in the early winter of 1979 Dr. Adkins had been selected by the National Cancer Institute to be one of a group of clinician researchers allowed to use thymosin experimentally on lung-cancer patients.

He now became the first patient in his own experiment.

On June 13 the maximum radiation dosage—6,000 rads—was finally reached in Dr. Adkins's treatment; he could receive no more radiation to his chest region. This occurred on a Friday. By the following Sunday the lingering mild nausea he had been experiencing gave way to overwhelming nausea. He couldn't keep any solids down and felt so exhausted that he didn't go into his office for an entire week. Ginger ale was the only nourishment he could keep down.

Concurrently he developed esophagitis, an inflammation of the esophagus that causes a burning sensation and pain. Esophagitis is also caused by radiation therapy. At one point he took aspirin and suddenly felt a burning, crushing pain in the middle of his chest. Although the pain didn't radiate to his neck or arms, he feared he might be having a heart attack.

Ever the scientist, he decided a couple of hours later to take another aspirin. He felt an identical pain and realized it was the combination of aspirin and esophagitis that caused it. He was relieved to learn that he didn't have heart problems to add to his list of ailments.

He spent the entire week in bed, reading and sleeping, as if hit with the most virulent of stomach flus. Throughout June he had been setting July 1 as his target date for a new beginning, and despite the setback he continued to look to it that way. He thought by then the effects of his radiation treatment would have diminished to the point that he could eat more and resume many of the surgical teaching and administrative responsibilities he'd had to ignore. The promise of early July grew in his mind until he was virtually consumed by it. He wanted to work, to operate, to teach, to play golf—"to have one more good summer."

But two new problems began to emerge, quietly at first. He noticed a blister on his lip. He examined it and wondered why it seemed to be enlarging. He also felt back pain for the first time. He thought the latter was probably caused by muscle spasms brought on by his coughing.

Concerned about his father's weight loss and relative lack of appetite, Mark Adkins bought him nutritional supplements. Dr. Adkins thought they tasted awful. Eventually they found one, Meritene, that he could tolerate. It was mixed with milk. When Faith Adkins mixed it for him at home she secretly added eggs and cream to get more nutrition and calories into him. She was distressed at seeing him become so thin.

Toward the end of June, Mark prepared to leave Washington to begin his surgical residency at NYU in Manhattan. He had found a small apartment on East 72nd Street.

The family had a big dinner that night, and when it was over Mark went up to the bedroom where his father was resting and told him he was apprehensive about leaving the security of home and joining an extremely competitive surgical residency program. His father reassured him. He said all young doctors are frightened by the prospect of residency.

They talked easily. Both realized, but never said, that Mark would be working hard and he would not be able to come home for a while. They knew this might be the last time they would talk face to face.

They both felt a deep sadness, but before the moment could become maudlin—something Dr. Adkins could never abide—they said their good-byes. Mark was soon heading for New York. Now only Paul and Bill, the two youngest sons, were living at home. David lived in an apartment on Bradley Boulevard and called or visited his parents often, more often than he had in the past.

On June 27 Dr. Adkins underwent another bone and liver scan, the best way to determine if the cancer had spread. The results would determine if he should begin chemotherapy. His opinion of chemotherapy had not changed. He would take it only as a last resort. He dreaded it in some respects more than death itself. He had seen its effects too often on too many patients.

The scans were negative; there was no detectable spread of the malignancy through the bloodstream. He was greatly relieved.

But two other problems kept nagging him. The "blister" on his lip didn't look like a blister—and it was definitely enlarging. His back also kept aching. After dinner Faith Adkins would gently massage away the pain and tightness. And as she moved her hands over his back she was saddened beyond telling to see her husband's once-strong body wasting away in front of her.

The first week of July, which he had hoped would mark a new beginning, began badly.

The lesion on his upper lip looked worse. He had applied a topical ointment, but it did no good and he grew increasingly worried. He picked at it, examined it, feared it. He visited Dr. Thompson, who told him it didn't feel like a blister or a cold sore. He didn't want to alarm Dr. Adkins but said it should be looked at by dermatology.

At his office on Wednesday, July 2, Dr. Adkins called Dr. Mervyn Elgart, a friend and chairman of the dermatology department at GW. He explained that he had something on his face he wanted looked at. Dr. Elgart invited him to come right up to his office, on the eleventh floor of the Burns building.

Examining the small reddish bump, Dr. Elgart at first suspected that it was a form of skin cancer, worrisome but something that could be dealt with. He surgically removed a wedge from the lesion's center for a biopsy and told Dr. Adkins he would have the results later that day.

That afternoon Carol Martin, a technician in Dr. Elgart's office, suggested that he might want to examine Dr. Adkins's biopsy himself, because it looked bad. Examining the tissue through the microscope, Dr. Elgart saw what Carol Martin was talking about. There were large dark cells beneath the epidermis—not on it as would have been the case in primary skin cancer. He had a sinking feeling that he was looking at metastatic disease, that the cancer was now spreading through Dr. Adkins's bloodstream.

He immediately called pathology and sent one of his residents to match the skin biopsy slides against the slides taken from the lymph-node biopsy in April.

An identical match.

There hours after taking the slice out, Dr. Elgart went down to Dr. Adkins's office. Dr. Adkins was sitting at his desk.

"Paul, I've got some bad news for you. The lip looks metastatic."

Dr. Adkins observed that it must have spread, thanked Dr. Elgart, and then fell silent.

His patients had taught him how to face the final crisis with strength and forbearance, and he now resolved to do the same thing.

After Dr. Elgart left, Dr. Adkins sat alone in his office turning the news over in his mind. It forced his hand on the chemotherapy, but more than that it meant the end of hope. He had not the slightest doubt that if the cancer had spread to his lip it was spreading everywhere, that malignant cells were starting new tumors, mounting new assaults, throughout his body. He could no longer remain in the soft embrace of illusion. Death was moving in, and he didn't have much time. He called Charlie Thompson. They talked only briefly. There was not much to say.

Paul Adkins did not sleep well that night, nor for the next few nights. He lay in bed thinking that he now had to live this ordeal out without flinching. His patients had taught him that; in a sense they had given him much more than he had given them. They had taught him how to face the final crisis with strength and forbearance, and he now resolved to do the same thing.

On Sunday afternoon of the Fourth of July weekend he experienced shortness of breath for the first time. He noticed it just walking up the stairs. He thought it possibly due to radiation pneumonitis, a buildup of fluid in the lungs caused by the long-term radiation therapy. Or it might be caused by loss of lung capacity from the disease, or an infection of some kind. He focused on the pneumonitis. It was a more comforting diagnosis.

He had a severe coughing spell Sunday evening, and coupled with the shortness of breath it made it difficult for him to breathe. Faith Adkins, hearing him coughing and struggling for breath, became alarmed. He downplayed the problem, said it wasn't so bad, but once, out of her hearing when he coughed so hard he wasn't certain he was ever going to catch his breath, he became frightened.

He took codeine for his cough and eased himself through the rest of the day and night. He planned to perform surgery the next morning, one of the few operations he'd scheduled in recent weeks, and he intended to go through with it. The patient was a sixty-year-old woman, the wife of another patient of his. She had a malignant tumor in her right lung, precisely where his own primary tumor was located.

The operating room was his arena, center stage, the place that demanded his utmost skill, judgment, and intelligence. In a real sense it helped define him. The OR also demanded total concentration. It was a private, insular world that shut out all concerns about himself. That would be helpful. He would be assisted this morning by two young physicians, Dr. John Walsh, a thoracic-surgery fellow and experienced surgeon in his own right, and Dr. Richard Coin, a younger surgical resident.

John Walsh, the son of a surgeon from Albany, New York, had come to GW in 1975 for his surgical residency. Dr. Walsh participated in his first operation in July of 1975. It was with Dr. Adkins, and he remembers it vividly:

Before he went into the operating room that day, other residents had warned him: Be extra careful; don't do anything that'll upset the boss. They didn't want some rookie's mistake to put him in a bad mood. At one time or another, they all had recognized the classic sign of the boss's displeasure in the OR: His green surgical pants would begin to slip down. No one knew why and no one ever had the nerve to ask, but when the pants slipped, every surgical resident knew that somebody was in deep trouble. He'd stare hard at the offender over his surgical mask, mutter a few oaths, and keep operating. All the while he'd be hitching up his pants with his elbows or yelling for a nurse to put a towel clip on them.

Heeding the warning of his fellow residents, Dr. Walsh went home and studied anatomy textbooks the night before that first operation. There would be no screw-ups, at least not by him.

When the operation got under way the

next morning—it was a relatively simple open-lung biopsy—Dr. Walsh was ordered by Dr. Adkins to cut the intercostal muscles between the ribs with a "bovie," an instrument similar to an electric cautery. Dr. Walsh began but, unaccustomed to the bovie, his hand slipped and the searing tip touched the lung and sizzled, making a small burn mark before he could yank it out.

Dr. Walsh stood in fear.

"The pathology report will just come back with a third-degree burn on the lung," said Dr. Adkins calmly.

Dr. Walsh was relieved.

Dr. Adkins next asked him to prepare the surgical staple gun, an automatic instrument that cuts and mends tissue.

Dr. Walsh had never held a surgical staple gun in his life until the nurse handed this one to him. He didn't know the safety catch was off. He brushed the trigger ever so slightly. Hundreds of staples shot into the operating room, hitting nearly everything, including the open chest cavity of the patient.

Dr. Walsh felt like a man waiting for his execution. Nothing happened this time, either. He couldn't believe it. The boss's pants hadn't slipped; not one harsh word had been spoken.

Dr. Adkins simply asked the nurse for a pair of surgical tweezers and calmly began plucking the staples from the patient's chest cavity.

Dr. Adkins asked Dr. Walsh to reload the staple gun. (That was the way he taught: They learn from mistakes.) Dr. Walsh reloaded it and Dr. Adkins told him just to hold it—he would do everything else.

"Yes, doctor," Dr. Walsh answered.

Dr. Adkins then directed Dr. Walsh to aim the staple gun at a precise spot in the open chest cavity. Dr. Walsh obeyed. Dr. Adkins said Dr. Walsh was to release the trigger when Dr. Adkins pulled his hand away. Dr. Walsh said he understood. When Dr. Adkins began removing his hand John Walsh released the trigger. Dr. Adkins's finger got caught in the gun's trigger mechanism. It hurt a lot.

He jumped. He screamed. He swore. His pants began to slip. The scrub nurse ran behind him as he hopped around the OR. She told him he'd have to change his surgical gloves now that they'd been torn.

"He's almost crushed the goddamn finger!" Dr. Adkins bellowed.

John Walsh, frozen with fear, could only watch as the operation was completed. The patient recovered. It was a while before the boss spoke a civil word to his new resident.

But over the years John Walsh had measured up. Dedicated, intelligent, kind to patients—he was the type of young doctor Paul Adkins liked.

Now, five years later, John Walsh had plenty of thoracic-surgery experience under his belt. Dr. Adkins, although his surgical skills were undiminished, was exhausted and out of breath.

Walsh noticed how labored his breathing was and considered saying that he could take over. He thought better of it, however, and Dr. Adkins persisted, more slowly than usual but carefully and completely and with excellent results for the patient.

Dr. Adkins later visited the patient in her room and told her the good news: Pathology had reported no lymph-node involvement. Her prognosis was excellent, he said. He was happy for her.

His shortness of breath grew progressively worse that day. By the afternoon it was difficult for him to walk across a room without being out of breath. Specialists at GW suggested that he admit himself as a patient. He called Charlie Thompson, who rushed over to the hospital to examine him.

Hundreds of staples shot into the operating room, hitting nearly everything, including the open chest cavity of the patient.

"For God's sake, Charlie," Dr. Adkins pleaded, "don't put me in the hospital." He feared that once in the hospital he would not come out alive. He'd seen it happen far too often to other people.

Dr. Thompson faced a dilemma because at least one specialist said it would be "atrocious" medicine not to admit Dr. Adkins. The specialist argued it was too early for radiation pneumonitis to hit, that it could well be something else and they had better find out.

Finally, after his examination of Dr. Adkins convinced him that the shortness of breath was probably caused by the pneumonitis dating back to the early reaction in early April, Dr. Thompson prescribed cortisone and walked Dr. Adkins to the hospital pharmacy and watched him take a large dose of it.

Charlie Thompson went home to a restless evening of second-guessing. He was fearful that he might have been wrong, that the shortness of breath was caused by something else, that it would grow more acute, that he might lose his patient. But that night at 8 o'clock Dr. Adkins called and said he was feeling much better. The cortisone had eased the breathing problem considerably.

The shortness of breath improved but did not disappear. Dr. Adkins brought an oxygen tank home and in the morning before he came to the hospital he would inhale a combination of pure oxygen and a broncho dilator mist to open up the passageways in his lungs. He repeated this process at the hospital at midday and again at home each night. It helped.

On July 11 he had another chest X-ray—he had them at regular intervals—which showed the pneumonitis had cleared up.

When Dr. David Rockoff read the latest X-ray he saw the implications immediately. The fact that the shortness of breath remained even though the pneumonitis was clearing meant that the lung capacity had diminished further and that the main stem bronchi, now squeezed even smaller, were causing problems. Nothing could be done for that. The cancer was galloping.

After consulting with Dr. Thompson, he decided to withhold these findings from Dr. Adkins. If Dr. Adkins realized he was slipping toward pulmonary failure he would know his time was almost up.

Dr. Rockoff now began to wonder if his Labor Day timetable had been too optimistic.

Dr. Adkins realized something was amiss, that he should have been over the pneumonitis by now. But the confusion between illness caused by the cancer and illness caused by his treatment was understandable. To keep his hopes alive—not for a long life but for a few more weeks or months—he wanted to believe his shortness of breath was associated more with his treatment than with his disease. As his expectations diminished, increment by increment, that was all he could hope for now.

During lunch at the hospital cafeteria with Bud Gusack, an internist interested in pulmonary medicine, Dr. Adkins asked him how long he'd seen patients with radiation pneumonitis last.

Dr. Gusack, who knew why his friend was asking the question, told him he knew of cases where they lingered for weeks, even months. When they left the GW cafeteria that day Dr. Adkins apologized for walking so slowly. But it was the only way he could move and still keep his breath. He finally quit smoking entirely—through the spring and summer he had been sneaking a puff here and there. Now he needed every last bit of air he could get into his lungs.

There were days during July when, except for the shortness of breath, he felt reasonably well. July 18 was such a day. He had been asked by a colleague to look at a patient, a middle-aged woman recently operated on for a brain tumor.

After the tumor was removed and examined by pathology it was discovered to be metastatic, with the lung as its source.

Paul Adkins wanted to be a doctor for a while, not a patient, and he quickly agreed to the colleague's request.

Dressed in a dark suit, blue shirt, red paisley tie, and his white physician's coat, he entered the woman's room in the neurological ward. She was lying in bed, surrounded by flowers. There was a jagged red surgical scar down one side of her head. Her husband, a small, self-effacing man, was sitting in a chair next to her bed.

Dr. Adkins sat in a corner of the room and spoke to her in a soft voice. He told the woman that he was a chest surgeon and that he had been asked to look into her case because the primary tumor was located in her lung, in the right upper lobe.

She interrupted him and began to cry. "The smoking," she said, "I always smoked too much. Why didn't I quit?" Then she began to sob. But she stopped abruptly and apologized.

Dr. Adkins explained that they would be doing some tests on her.

She burst out again, her speech weepy and slurred: "I just want to see my kids graduate next June. I don't care what you do. I don't care if my hair turns white. . . . "

Her husband soothed her and she calmed down again.

"We have to get to the bottom of this," Dr. Adkins said. "We want to get some sputum to find out if there are any abnormal cells."

She agreed. Anything, she said, anything. Then she erupted again, screaming about a doctor, not her primary doctor but some young doctor, who'd come in and told her that she'd be in the hospital all summer and that nobody knew what would happen to her.

Dr. Adkins walked over to her bed. He reached out to touch her ankle and gently squeezed it. "I can't speak for or defend everyone in my profession," he said softly. "I'll tell your doctor about the complaint." He said good-bye and walked out to the nurses' station to examine her chart.

Her husband followed and asked Dr. Adkins about the patient's prognosis. Dr. Adkins told him that a cure was unusual but that some people lived with the disease for a long time. This was the hope he harbored for himself.

"My wife is distraught," the husband said.

"I don't blame her," Dr. Adkins answered. He'd read in the chart that the woman's chest had been X-rayed just six weeks earlier in a doctor's private office and that nothing had been found.

"A lot of doctors in private practice put X-ray machines in their offices to make money," he said later to a friend, "but they can't read the X-rays and they miss things."

Dr. Adkins walked back toward his office knowing full well that no matter what treatments the woman underwent, she would never see her children graduate the following June. Four to six months was his best estimate.

He phoned the woman's physician and told him of her complaint about a young doctor frightening her. Doctors who talked to patients like that were professional crepe-hangers, he said to a friend later, and he considered their attitude not only rude but unethical. He'd called a few of them on it. Hard.

Later that afternoon he went to radiation therapy for spot treatment of his hip metastasis, which was shrinking. He also received another of his three weekly shots of thymosin. That weekend he went out for nine holes of golf at Burning Tree.

"For God's sake, Charlie," Dr. Adkins pleaded, "don't put me in the hospital."

He called it his Rubicon, and soon he would have to decide whether to cross it—whether or not to take chemotherapy. Toward the end of July he went to see Charlie Thompson. The time was quickly approaching when not to decide was to decide.

They had grown ever closer. They spoke daily and saw each other a few times a week. Besides his wife Dr. Adkins felt Dr. Thompson was most responsible for sustaining him during his illness. Dr. Thompson now asked if Dr. Adkins had come to grips with the chemotherapy decision.

He said he was leaning toward chemotherapy and asked what Dr. Thompson would do if he faced the same decision.

Dr. Thompson said he'd take a chance on the chemotherapy. Without it, there was none. You're used to taking chances, he told Dr. Adkins.

He meant that Dr. Adkins had taken several professional risks. For one thing, he'd performed the first coronary bypass operation in Washington several years earlier, only to abandon heart surgery in the mid-1970s amid an internal battle at GW.

Dr. Adkins was still agonizing over the chemotherapy decision as they walked from Dr. Thompson's office to his examining room.

Dr. Adkins's chest seemed remarkably clear to Dr. Thompson and his cranial nerves appeared intact. No sign of a brain tumor. His weight was holding at 150.

Dr. Adkins said his back was still hurting and that he often had to get up in the middle of the night to take a hot bath to relieve the aching. Dr. Thompson palpated the lymph nodes and good-naturedly scolded Dr. Adkins for feeling them himself. "It's my job," he said.

They went back to his office and Dr. Thompson passed him a box of Russell Stover chocolates; he wanted to get calories into him. They chatted easily about the weather and the Republican Convention, and then Dr. Adkins moved to leave.

"Paul," Charlie Thompson said as they were parting, "you've got a chance. Don't forget."

"I'm not throwing in the sponge."

"You're damn right you're not. I'm not going to let you."

If the chemotherapy didn't go well, if the side effects were more severe than anticipated, Dr. Thompson said, "I'll buy us a case of whiskey and we'll just forget about it."

Dr. Adkins's 55th birthday was July 21, a Monday. A party was held the following Friday.

His shortness of breath slowly grew worse. He would feel good one day and bad the next, but he would never feel as good on his best day one week as he had on his best day the week before.

The coming birthday stirred conflicting emotions. He knew it would be his last and he knew he would begin chemotherapy on July 28. He had finally decided to have it because he thought that it might extend his life and that a metastasis in the brain could be just as debilitating as chemotherapy. But his decision gnawed at him that week. In addition, he felt a small growth inside his mouth and thought it was a tumor. It turned out not to be, but it preyed on his mind. His nausea continued and his esophagitis flared up and his back pain continued to worsen. He hadn't had a full night's sleep in weeks.

His secretary, Cindy Fisk, called him Friday morning to remind him he had a CT scan of his chest scheduled that afternoon. He usually remembered everything, but lately he had been forgetting things, and he had forgotten the appointment.

She asked whether, in light of everything, he wanted to cancel the birthday party. "No!" he yelled. It was his body and he was damn well going to do with it what he wanted.

Two hours before the party he had the CT scan. Dr. Rockoff saw that his left main stem bronchus was now only three millimeters wide. Its normal width was ten millimeters. The right one was down to six millimeters. Not enough air was getting into the lungs, which themselves were losing function. Dr. Rockoff had hoped the bronchus to the right lung would provide sufficient air flow, but the tumor was surrounding and strangling it—impeding not only air flow but also proper oxygenation of the blood. Cerebral anoxia—lack of oxygen in the brain—was the reason he had begun to forget things. Dr. Adkins gave no indication that he wanted to know what the CT scan revealed. Dr. Rockoff lied to him, said the situation was unchanged.

Old friends, residents, nurses, fellow doctors —more than 100 persons—came to the birthday party, one from Morgantown, West Virginia.

Dr. Adkins sat quietly for a long time, trying to get into the mood of the party. People came up to talk with him and at first he was polite but not very responsive. But slowly, as the warmth enveloped him, as he saw the genuine outpouring of affection and love, he began to respond. He was deeply moved by it all.

They presented him with a number of books, novels and other light reading, and then Dr. Vincent Iovine, a retired surgeon and old friend, stood up to speak. He thanked Dr. Adkins for everything he had done for all of them. Dr. Adkins stood and told them he was happy for everything they had done together.

Dr. Thompson drove him home after the party. On the way they talked about Faith Adkins, how she was holding up, how she would do when he was gone. Dr. Adkins knew time was closing in on him, knew without being told that his lungs were slowly shutting down.

When they arrived home, Dr. Thompson came in with him and the two of them and Mrs. Adkins talked in the den. Monday would be the day of chemotherapy. Dr. Adkins reached into his pocket and handed his wife a card. It was for a wig shop. He'd done some research, he said, and this was the best place around. It was only partly a joke, Dr. Thompson realized. His patient still had a healthy vanity.

Dr. Thompson rose to leave. He hugged Faith Adkins and said that the three of them had to stick together because they were all in it together. Then he left.

On Sunday, the day before his chemotherapy, Dr. Adkins played nine holes of golf. That night he watched television and drank five light beers. He had to hydrate himself, he kidded Dr. Thompson when he called.

Dr. Thompson encouraged him, told him to have a few beers, to play a little golf, to have a good day when he could. You're playing against the house, he said, and the house always wins. But it helps to make a good roll every now and then.

Receiving the chemotherapy, a combination of cis-platinum and vindesine, took seven and a half hours—long, boring, and uncomfortable hours, even though several colleagues came by to visit. Dr. Adkins sat in a lounge chair in the hematology section of the Burns Building as the drugs dripped into him from an IV. He was too restless and uncomfortable to read or sleep. A little before 4 PM he called Dr. Thompson—who had come there at 7:30 AM to make certain every precaution had been taken—to tell him that his back hurt like hell but that he felt no other ill effects from the chemotherapy, which was finished. His wife was picking him up, he said, and he was going home.

Dr. Thompson canceled the reservation for a hospital room he'd made in case of an immediate adverse reaction. He was happy that Dr. Adkins had withstood the treatment so well.

> **"I'm not throwing in the sponge," Dr. Adkins said. Charlie Thompson replied, "You're damn right you're not. I'm not going to let you."**

Dr. Adkins felt well most of Tuesday, but that night, just after dinner, he could not keep any food down.

It continued unabated the next day, and the next. His strength slipped away and it was even difficult for him to hold down liquids. He grew weaker. He found himself unable to get out of a chair without blacking out. His inability to eat or drink, coupled with a side effect of vindesine, was causing dehydration and low blood pressure.

By the following Monday he knew he needed help. His wife drove him to the hospital and he went directly to hematology, where he was put on IVs to be rehydrated. Three colleagues, Steve Pett, John Walsh, and Newt Tsangaris, came by and cheered him up. They told jokes while he waited for the IV fluid to drip into him.

By Wednesday, August 6, he was rehydrated, and he bounced back a bit. Although he was still very weak, the acute dizzy spells had passed and he was once more able to go to the office and do some administrative work, answer letters, talk on the phone. He still insisted on coming to work. Someone called and asked how he was doing. "Not too bad," he answered, "except they're trying to kill me with the chemotherapy."

His back was now so painful that at least twice a night he had to take baths, which provided some relief. He rubbed on Ben Gay and his wife continued to massage him at night.

His breathlessness was growing worse and he was coming to the conclusion that he would not take the full treatment of chemotherapy again. He took only weekly shots of vindesine, and he was very close to ending those. He remained understandably confused over what was making him feel so terrible—the chemotherapy or his lung cancer. He knew it was probably a combination of the two, but he wasn't sure which one was the larger problem right now.

His weight dropped further and he found himself unable to fit into any clothes except old golfing slacks and sports shirts, but he still went to his office. He experienced no hair loss. It would take two or three full doses of the chemotherapy for that to happen.

A new complication now developed: pericarditis. An inflammation of the sac around the heart, it was thought to contribute to the dizziness he was experiencing when he stood up quickly. His doctors believed the cause of the pericarditis was either radiation or a metastasis.

He considered the new complication an incidental finding and showed no interest in indentifying its cause.

Speaking to a friend in early August, he said he sensed things were drawing to a close. He said he had no regrets. His life had been fulfilling, and he'd accomplished more than he'd thought he would. He should have spent more time with his family, but medicine has a way of keeping you working long hours. He was proud of his work to reform exams for the American Board of Thoracic Surgery and of his teaching at GW, and the way he'd built up the surgical department there. He'd miss seeing grandchildren and retirement. When he became too much of a burden at home he'd admit himself to the hospital, he said.

He hadn't embraced death as a release yet, but he was resigned to the fact that it was coming soon. He didn't know when and he didn't want to know. Depression, anger, and frustration were all still there inside him, but they were not dominant emotions any longer. He was closer to finding peace.

He got up one morning in early August and the shortness of breath, the back pain, the dizziness, the weakness, and lingering nausea were all worse. He told his wife: "Every major body system I own is screwed up." He faced a dilemma: He didn't eat because he was afraid of the nausea but the lack of nutrition made him weaker.

He kept going to work. Mrs. Adkins had to drive him there. "When you stop caring, it's all over," he said.

On Thursday evening, August 7, his eldest son, David, came to visit, as he often had recently. They spoke about many things, including work and golf.

The reprints of his Atlanta speech had just arrived and Dr. Adkins signed one "with love" for David, who said goodbye that night buoyed by the impression that his father was in good spirits.

Chest X-rays that week showed a further loss of lung volume and indicated that his lungs were now taking in more air than they could exhale, a condition similar to emphysema.

Old friends drove from Richmond the weekend of August 9-10 to visit him and his wife. "I guess they want to see how bad I look," he joked to a telephone caller. He knew they would politely say the opposite.

Other friends came over to the house that Saturday, and they all planned to go out to dinner at Kenwood Country Club. But Dr. Adkins had to spend much of the day in bed and he didn't have the strength to go to dinner that evening. He told his wife he couldn't believe how fast he was sinking.

On Sunday night, lying flat in bed, he became short of breath, the first time he'd experienced that while in bed. He knew he wasn't going to get that one last good summer.

On the afternoon of Monday, August 11, after working in his office briefly, he went for radiation treatment of his lip. He had to steady himself against walls or rails as he walked.

At the radiation-therapy office he knew he could go on his own no longer. He called Dr. Thompson and said he couldn't manage at home anymore, that there was no sense in going there. He'd already told Faith, he said.

Faith Adkins called Dr. Thompson from her home a short while later. She knew her husband's decline was rapid, she knew he wouldn't want to go into the hospital unless he felt he was at the edge. Was he in danger? she asked.

Dr. Thompson said, "Knowing what he has, I'd have to say yes. "Let's play it day by day, Faith. That's all we can do."

Dr. Adkins waited in a wheelchair near radiation therapy and when a young resident came by and offered him oxygen to assist his labored breathing he refused it. He didn't want people to see him like that, not here.

Dr. Thompson arrived at 2:30 PM. When their eyes met, Dr. Adkins gave him the thumbs-down sign. His face reflected sadness and defeat. Dr. Thompson cut through the red tape and got Dr. Adkins a private room in the thoracic-surgery suite on the sixth floor. Dr. Adkins was officially admitted, at 4:30 PM, on the floor he'd run for ten years.

Everybody who had worked with him in the thoracic-surgery suite wanted him there now that he had been admitted to the hospital, wanted to be near him, to take care of him.

Shortly after Dr. Adkins was admitted, Dr. Richard Coin, the young resident who had assisted him in his last surgical procedure, came by to take some blood for blood-gas readings. Dr. Adkins said he wanted oxygen. Now.

Dr. Coin said the blood should be drawn while Dr. Adkins was breathing room air. To hell with the blood gases, he gasped, give me the oxygen. This was the chairman of surgery talking. Dr. Coin brought the oxygen.

He hadn't embraced death as a release yet, but he was resigned to the fact that it was coming soon.

The blood sample was taken afterward. The blood-gas readings came back early that evening, and they were not encouraging. Dr. Thompson had hoped they would indicate that Dr. Adkins was dehydrated—because dehydration could explain his increasing shortness of breath and weakness. But the blood-gas results weren't bad, and that could mean only that the lungs were.

More chest X-rays were taken, and Dr. Thompson, Dr. Rockoff, Dr. Walsh, and Dr. Allan Ross, the head of cardiology, met in Rockoff's office to discuss them. Dr. Rockoff had the last six X-rays arranged in sequence. He pointed out that in the last week the heart had enlarged by a few more millimeters as a result of the pericarditis and, more important, that there was now a fluid buildup in the upper part of the right lung and more air had been trapped in both lungs. The situation was growing critical.

Dr. Ross said another heart echogram was needed to determine the present extent of the pericarditis. There was a fear of tamponade, a condition in which the fluid buildup in the pericardium becomes so acute that the heart is squeezed. Tamponade would cause a cardiac crisis Dr. Adkins would not be able to withstand.

Dr. Thompson agreed to the heart echogram but insisted that he be kept in-

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formed every step of the way.

"Charlie," Dr. Ross said, "I'll call you the minute I know anything."

The oxygen helped Dr. Adkins breathe and talk with less difficulty. Visitors came in and out. They found that he still had a sense of humor. "All things considered," he said, "it's a lot better being a doctor than a patient."

After he was given the heart echogram he asked a visitor to see if there was a bathtub in the bathroom. Dr. Adkins was greatly relieved to learn that there was. He still had to take a couple of hot baths every night to relieve the back pain.

Alone with a friend, he began talking philosophically. What is life worth, he asked, when you have to lie down and rest for a half hour to recover from shaving? He said he had no regrets about refusing the radical treatment offered at Sloan Kettering but he did regret undergoing chemotherapy. He should have taken his chances with the radiation and quit all other treatment. The chemotherapy made him feel miserable. It wasn't worth it. "I guess it's the Lord's way to have you go in small pieces like this," he said, "to get you feeling so bad that living is worse than the fear of dying."

Dr. Thompson and Dr. Ross met in the latter's office to study the results of the heart echogram. There had been no major changes from the one taken a week earlier. Dr. Ross, a young man and new to GW, looked at Dr. Thompson with tired eyes and said: "We can tap the pericardium and get the fluid out, but it's just a matter of time, and not much."

Mark Adkins, calling home from New York that Monday night, learned from his brothers Bill and Paul that their father was now in the hospital. He waited until after his mother had returned from visiting before calling his father at the hospital. His father spoke with great difficulty; every breath was labored.

Dr. Adkins told Mark that he was dehydrated again but that the doctors were going to hydrate him and give him some hyperalimentation. He should be better in a couple of days, he said.

Mark, realizing that it was a struggle for his father to talk, kept the conversation brief. He hung up believing what his father had told him—that he'd be a lot better in a couple of days.

That night Dr. Adkins rested upright in bed, tubes feeding him oxygen through his nose, and watched the Democratic National Convention on television.

He did not sleep well.

On Tuesday he was exhausted. A steady stream of visitors came by, but Dr. Adkins, sedated by codeine for his back pain, drifted in and out of sleep much of the day. Mrs. Adkins spent several hours with him. She knew he was fading. She didn't know how long he had.

By Tuesday night, despite the oxygen and the broncho dilators, Dr. Adkins's breathing became more difficult and Dr. Thompson gave him Valium to help him relax and sleep. Dr. Adkins had to sleep sitting up in bed; he couldn't breathe when lying down. Dr. Thompson stayed in his room until midnight, trying to ease his pain.

Late that evening Dr. Adkins struggled to get to the bathroom, and when he returned Dr. Thompson helped him back into bed. Their hands met. Dr. Adkins, the least demonstrative of men, clasped Dr. Thompson's hand tightly and said in a voice that was little more than a gasp: "Charlie, thanks for taking care of me."

Dr. Adkins clasped Dr. Thompson's hand tightly and said, "Charlie, thanks for taking care of me."

At 1 AM Wednesday the time came when his lungs couldn't function well enough to keep his body going. He was suffocating. To compensate for the fact that his lungs could no longer oxygenate the blood properly, his heart began to race, to get oxygen to the deprived tissues.

Dr. Adkins wanted to fight, but he had nothing left to fight with. He didn't want "heroic measures" to be taken after his mind slipped permanently from consciousness. He wouldn't become a vegetable; he had an understanding with Dr. Thompson about that.

Three years earlier Dr. Adkins's surgical mentor, Dr. Brian Blades, his predecessor as chairman of surgery at GW and a close friend of Charlie Thompson, had been kept alive for three days by a respirator after he had a cerebral hemorrhage. Dr. Thompson went into Dr. Blades's room and turned off the respirator switch. A moment later Dr. Adkins walked in and, seeing what Charlie Thompson had done, told him it was the right thing. They both watched as Dr. Blades, then in his seventies and a friend of both of them, died within minutes. Earlier this summer, Dr. Thompson, recalling the decision made on Dr. Blades, said: "When the time comes, Paul knows what I'll do."

Dr. Adkins's breathing had now become more distressed. Dr. Coin, who had gone without sleep for more than twenty hours, was summoned by the night nurse. He saw that Dr. Adkins's system was begging for oxygen. Dr. Coin gave him as pure a mixture of oxygen as possible and offered a number of medical alternatives to keep him going.

"Look," Dr. Adkins gasped, his voice almost a whisper, "I just want to be comfortable."

He was given more tranquilizers.

At 4 AM Dr. Adkins took another turn for the worse. He was now gasping for every breath. Like a drowning man, he was unable to get air. He asked Dr. Coin to take him to the intensive-care unit—like the water's surface, a place where a struggling man might breathe.

Dr. Coin said Dr. Adkins didn't want or need that kind of machinery. Instead, he gave him special treatments to open up the bronchial passages as much as possible.

Dr. Adkins continued to struggle for air.

At about 7 AM Dr. Thompson arrived. Dr. Adkins's heartbeats were now at 160 or more a minute, more than twice as fast as normal. He was still gasping. Dr. Thompson knew the end was near, and he knew Dr. Adkins knew it. They had said their good-byes the night before.

Dr. Thompson gave him Demerol to help him rest and at 9:30 that morning left for his office, where his waiting room was filled with patients. He hadn't been there long when he was called by the floor nurse, who said Dr. Adkins needed to see him. Dr. Thompson asked his receptionist to tell his patients to go home and then hurried over to the hospital.

Now unable to speak except in gasps, Dr. Adkins asked Dr. Thompson about the intensive-care unit. Should he go there? It was the survival instinct talking.

"No, Paul," Dr. Thompson said. "I don't want you to go over there and have them stick in a bunch of tubes."

Dr. Adkins nodded. He understood. He whispered his thanks.

Dr. Thompson asked if Dr. Adkins wanted a priest and he nodded yes. Dr. Thompson summoned one from St. Stephen's, which was nearby.

Then Charlie Thompson spoke his final words to his friend and patient, the man he'd cared for all these months: "Paul, I'm going to give you some rest."

Dr. Adkins nodded his approval a final time.

Dr. Thompson gave him Demerol again, and Dr. Adkins slipped into a deep sleep.

Mrs. Adkins had arrived and soon began calling her sons to tell them to come to the hospital. Mark could not be reached in New York right away. A message was left for him.

A priest, an elderly man who walked with a limp, arrived and administered the last rites of the Catholic Church.

At 11:15 AM Dr. Thompson switched from Demerol to morphine, a stronger depressant, which slowed down Dr. Adkins's respiration rate markedly. Dr. Thompson gave him morphine again at 12:30 PM. One of Dr. Thompson's former residents came by and observed what was happening. He put his hand on Dr. Thompson's shoulder and told him he was doing the right thing.

All morning doctors and nurses had kept coming up to the room, gathering around, many weeping. Mrs. Adkins remained at his bedside, weeping at times but also strong. She had never expected it to come this quickly, she said.

Early in the afternoon Bud Gusack came and stood by the bed. The oxygen tubes had been removed earlier, and Dr. Adkins, still propped up, was breathing very slowly. Faith Adkins looked up and spoke: "You know, Buddy, he gave me his heart and his whole life and he asked so little of anybody else." They both wept.

Three of his sons had joined the vigil. David and Bill sat quietly, watching their father with solemn faces. Paul was at his father's side, holding his hand.

Mark Adkins heard himself being paged at Bellevue Hospital at approximately 2:15 PM. He wasn't alarmed. He was on call and it was routine to be paged

He walked into the surgery office for his message. The secretary said a Dr. Tsangaris from GW Hospital had called. Mark realized what it was about and called back immediately. Dr. Tsangaris's voice was heavy. He told Mark his father was having respiratory difficulty.

"How bad?" Mark asked.

"He's having a very difficult time," Dr. Tsangaris said.

Then Mark asked whether Dr. Adkins had been put on a respirator, and was told he hadn't been.

Mark agreed with the decision and said he would get there as quickly as he could.

Dr. Walsh, who had come up several times earlier to look in on Dr. Adkins, reappeared in the early afternoon, his eyes reddened. He was due in surgery but said he wasn't up to it. He said he couldn't bring himself to operate when Dr. Adkins, the man who had trained him and whom he adored, was dying. Dr. Thompson, weeping, said it was his duty. Dr. Walsh left for the operating room.

Dr. Adkins had received fifteen milligrams of morphine approximately every hour. Dr. Thompson administered it each time because he wanted no one else to bear any responsibility.

Dr. Adkins's heart was strong. It continued to race to make up for the failing lung functions. But it would have to give out soon.

At 4:05 PM Dr. Thompson gave him another fifteen milligrams of morphine.

Mark Adkins still had not arrived. David, Paul, and Bill remained at their father's side. So did Mrs. Adkins, joined by her younger brother, Jon Jouvenal. Dr. Thompson told them it was almost over.

"I'm not Marcus Welby," he said. "I can't predict when. It could be ten hours, but I don't think it will be that long."

Dr. Adkins had not been conscious since 11 AM. He was in coma. At 4:25 PM Mrs. Adkins let out a soft cry. Her husband had stopped breathing. Several doctors standing outside rushed in.

Dr. Thompson pronounced Paul Adkins dead at 4:30 PM, precisely 48 hours after he was admitted to the hospital. His death came four months and eleven days after he saw the first X-ray and knew that he was looking at his own obituary.

Mark Adkins caught the 4 o'clock shuttle in New York and landed at National at 5 PM. He raced from the terminal to the subway and got off at the Foggy Bottom stop. He ran up the steps of the long escalator. As he approached the top he had a full view of the front of GW Hospital. The flag at the entrance was at half-mast.

Charlie Thompson did not sleep well that night. Should he have done more to keep Dr. Adkins alive a while longer? He agonized until the next morning, when the autopsy was held.

Even in death Dr. Adkins had wanted to teach. They would learn from his body.

In the morgue on Thursday morning Dr. Thompson immediately recognized the high arches of Dr. Adkins's feet. He covered them with the sheet. He watched the autopsy with Dr. Walsh, who attended as a final gesture of respect.

The amount of cancer that had invaded the body was staggering to them. Both lungs were heavily infiltrated, even more dramatically than the X-rays had indicated. So were the kidneys, the adrenal gland, and the liver. The pericardium around the heart was also invaded. The heart itself had been invaded, and so had the spine, and so had the cracked rib, the cause of his back pain.

Dr. Thompson now knew that no more could have been done, that administering the morphine had been the only humane course open to him, that the fact Paul Adkins lived as long as he did was a testament to his tenacity and fierce will.

That night Charlie Thompson slept.

The wake was held at the Pumphrey Funeral Home in Bethesda. Scores of people came: doctors, old patients, friends, neighbors. In the crowd a man looked at the flag-draped casket and wept. Where is Dr. Adkins's wife? he asked. Where are his sons? He had to tell them something. He had to tell them what a great man this was, this man who had saved his life, who had put a pacemaker in him thirteen years ago.

He walked over to Bill Adkins, only eighteen, but looking older in his dark three-piece suit. The man told him all the things his father had done for him. Then he found Faith Adkins and told her too. She reached over and hugged him, and gently kissed him, and the man left.

The funeral was held at Little Flower Catholic Church on Saturday, August 16. Dr. Adkins had asked his wife during the summer not to forget the passage in William Cullen Bryant's poem "Thanatopsis" when he died. He wanted it read at his funeral.

So live, that when thy summons comes . . .
Thou go not, like the quarry-slave at night,
Scourged to his dungeon, but, sustained and soothed
By an unfaltering trust, approach thy grave,
Like one that wraps the drapery of his couch
About him, and lies down to pleasant dreams. □

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"WHEN THY SUMMONS COMES..."

Those words, taken from a poem read at Paul Adkins's funeral, appear at the end of his story.

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If you smoke, or are a physician or other professional in contact with smokers, there are ready sources of help. More than a dozen organizations in DC have joined forces on an interagency level to reach as many individuals as possible with the latest methods in smoking cessation, as well as information on prevention and nonsmokers' rights.

Contact:

Mr. Shane McDermott, Chairman
DC Interagency Council on Smoking and Health
c/o DC Lung Association
1511 K St., NW #1043
Washington, DC 20005
202/783-5864

or call either of the following:

American Cancer Society
1825 Connecticut Ave., NW
Washington, DC 20009
202/483-2600

American Heart Association
2233 Wisconsin Ave., NW
Washington, DC 20007
202/337-6400

Reprints of this article are available through the DC Lung Association or American Cancer Society.

Donations to the Paul Adkins Memorial Fund are invited. All proceeds will be used to further anti-smoking efforts. Checks should be made payable to Paul Adkins Memorial Fund, c/o DC Lung Association, 1511 K St., NW, Washington, DC 20005.

WASHINGTONIAN

RESPONSE OF MARTIN H. COHEN, M.D., CHIEF, ONCOLOGY SECTION, VETERANS' ADMINISTRATION MEDICAL CENTER, WASHINGTON, DC, TO A WRITTEN QUESTION SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question. Please give me your views on the relationship of bereavement counseling to hospice care and, specifically, your views on the extent to which counseling and assistance to the family, both before and after the patient's death, must be an integral part of a hospice-care program.

Answer. Bereavement starts as soon as the patient and his loved ones are told that death is inevitable. All parties affected by this knowledge suffer and grieve because lifelong ties are about to be broken. The patient suffers from feelings of loneliness and isolation from his family and from helplessness in the face of his illness. His loved ones also suffer because of their inability to adequately help the patient. Family planning for the future is often delayed or ignored because plans must obviously exclude the dying patient. As time passes, the patient progressively deteriorates physically and mentally until only fragments of his personality remain. During this last period, the loved ones begin to hope that death will come soon. This wish often engenders guilt.

In light of these considerations, it is clear that bereavement counseling should start at the time a terminal illness is diagnosed, not after death. My staff and I have recognized this need for many years and reference is made to bereavement in the bracketed section of the attached article (p.1183) describing our oncology ward. Our concern about bereavement and the shortcomings in treating it have led us to develop a protocol to guide our management of grief and anguish. Hopefully, with adequate funds for personnel, this type of program could be widely implemented in VA medical centers. Briefly, we plan to foster an interaction among the patient, his loved ones and specially motivated nurses who are either trained or long experienced in dealing with the concerns of the terminally ill. Together, they will form a therapeutic alliance. This alliance will begin with the establishment of a trusting relationship. Subsequently, practical problems will be worked out, personality assets capitalized upon and remaining patient resources utilized. This leads into the therapeutic phase where preparation is made for the termination of the relationship. Discussion, in the therapeutic phase, centers around concepts of life, death and afterlife. The theory of eternal progression is often a gratifying speculation that encourages both patient and family toward achievement and optimism even in the face of imminent death. By forming a therapeutic alliance between the patient, mediating nurse and his family, both hidden and obvious personal values are brought into focus so that all affected individuals derive support and solace throughout the terminal illness and beyond. We stress that last achievements and struggles are worth the effort, that they can be satisfying and that they may be carried into the next phase of existence. In the final days, the therapeutic alliance between the nurse and the family helps them deal with their feelings of guilt and inadequacy in the face of death. By the time the patient dies, much of the bereavement process should have been accomplished, and the family should feel relief that the patient's suffering has ended. This should help them to make the adjustments needed to continue their lives.

To specifically answer your question, I agree that bereavement counseling is very important. Because bereavement is not yet adequately managed it could require six months of counseling, after death, for adjustments to be made. As indicated above, however, this is not optimal. Our goal is to develop techniques that will allow bereavement counseling to be concluded, in most cases, at the time of death. We are optimistic that this can be achieved.

2C North

Does emotional involvement between patients and staff preclude objectivity? Not on 2C North, where empathy has resulted in creative —even groundbreaking—nursing care.

By Anita Johnston-Early

2C North is a unit that can boast of few physical amenities. The architecture is antiquated; private and semi-private rooms and bathrooms are scarce. It is where patients come for treatment if they have cancer of the lung, prostate, liver, or stomach, or mycosis fungoides, a rare lymphoma.

Some might reject 2C North at first glance, or cringe at sharing a room with three patients. A few would find it distasteful to walk down a corridor to a bathroom. Some would have to be convinced that the treatment here is very good and not easily duplicated elsewhere.

But because of the superb care given by a caring staff, the environmental inadequacies of 2C North are hardly noticeable.

2C North restores those whose emotional reserves have been severely depleted by the shock of knowing that they have cancer. Where the earth once had been crumbling beneath, 2C North builds a firm foundation. Nurses on 2C North are not afraid to touch and hold or to speak about cancer and dying. Baths and bedmaking are often delayed as nurse and patient sit side by side assuring, listening, and sharing. Together, we ask what can be done today to make life more pleasant, what can be achieved with the resources at hand. Nurse, patient, family, and doctor rejoice together when an x-ray shows that a tumor is shrinking. And when it is painfully clear that treatment has failed and there is no where to go but into somebody's arms, those arms are waiting on 2C North.

The 2C North nursing staff is involved. They are sometimes warned that involvement might mean a lack of objectivity, but they have learned long ago that the opposite is true. Involvement is not only productive, it is also natural. Yet since it can be draining, the nurses are advised and supported by a psychiatrist, who years ago was an intern on 2C North. With him, they learn to deal with their emotions and get to the core of problems. The staff are able to pool and complement their strengths so effectively that together, they have become an imposing force.

Empathy is the unit's most valuable characteristic. Indeed, it is difficult *not* to learn it; for superficiality is quickly abandoned in the face of acute hurt and need. Patients and families continually teach and reinforce the concept of empathy in one another. Roger and his mother are two of many we have learned from.

Roger was an unassuming 38-year old patient who came to us from Appalachia. His cancer was so widely spread that we could hope only for a transitory remission of his disease; that's all he ever had. After a six-week hospitalization for intensive chemotherapy, Roger was discharged to return every three weeks for maintenance treatment. Within a few months his cancer, again growing, was unresponsive to new treatment. Roger was not sorrowful. He did not complain. He just accepted what was happening.

He asked that his mother be called to share his last days with

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him. She arrived carrying only a paper sack. She remained at his side, helping the nurses bathe and turn his now edematous and jaundiced body. She slept in a chair when he slept. She coaxed broth into his ulcerated mouth and gently rubbed his aching limbs. A touch, a glance, words of assurance and encouragement communicated that this was just another hardship to be endured. They had put up with plenty before, and they could get through this now. Roger wasn't to worry, "because she'd be just fine." He would smile at her confidence and then sleep again for a while.

When it was obvious that he was dying, Roger called his mother to his side and whispered his good-bye. When he died, she turned from him, seeming to accept her fate as he had, and left his room carrying her paper sack.

It was hard for those of us who had shared those days with her to say good-bye. We felt a kinship with her and she with us. Many of our patients and families spend weeks, months, and even years undergoing treatment. The bonds between us grow, regardless of how much time we have together. During holidays, many family members return to reminisce and bring gifts. Occasionally, they telephone or write as new adjustments are being made in their lives. And then one day we realize we haven't heard from one of them in a long time, and we know that for him or her, adjustment is complete.

While the greatest nursing contributions we make are in day-to-day bedside care for patients, we have made other unique and worthy contributions. One had to do with the care of the patient with mycosis fungoides (MF). MF begins with skin tumors, ulcers, or plaques that are sometimes thick and leathery. Because MF is difficult to diagnose in its early stages, patients often spend years going from doctor to doctor. At diagnosis they may be bitter, depressed, and withdrawn.

The skin lesions break down, become infected, and drain. The odor is repulsive. Often a person's entire skin surface is involved. Intravenous therapy becomes difficult to administer, and bathing and topical application of creams tedious and unpleasant. Eventually the internal organs are affected. The disease now becomes fatal.

Alice is the research nurse in charge of MF patients on 2C North. She is young and pretty, with clear, smooth skin. It is impossible not to be struck by the physical contrast between patient and nurse. But Alice seems to see past the smelling, oozing lesions. She patiently instructs each person in the use of topical chemotherapy and creams, using video tapes that she has prepared. She listens attentively as patients repeat the instructions back to her. With proficiency she gives IV therapy in veins hidden beneath hard plaques.

Alice faithfully supports her patients through the slow and difficult months of electron beam therapy that sometimes further damages the skin by reddening or burning it. She gives her patients jobs to do to help them remain productive and offers suggestions on how to make positive changes in their lives. She helps her patients develop inner resources that strengthen their personalities. Based on her experience with MF, Alice has written several papers that not only provide guidance on various aspects of the disease, but also give insight into support of cancer patients in general.

Making a difference in each patient's care is the norm on 2C North. But the nurses also have unique opportunities to do clinical research that can affect the lives of many patients. One nurse conducting studies in lung cancer noticed that a large percentage of her long-surviving patients with small-cell lung cancer had stopped smoking at or before their cancer was diagnosed. All had previously been heavy smokers. She had not been asked to record this information, but because she knew her patients so well, this phenomenon became apparent to her. She began keeping records on new patients, and after several years, her suspicions were confirmed: The patients who had stopped smoking at or before diagnosis had a better response to treatment than those who continued to smoke. These results were published in a major medical journal and widely circulated by the press.[*] The finding prompted physicians to advise their patients that smoking abstinence was an aid to treatment. It encouraged scientists to test whether smoking abstinence was associated with longer survival.

Another challenge that became a triumph concerned patients whose tumors obstruct large and small airways so that their lungs can no longer accommodate oxygen, causing these patients to smother. While these individuals were clearly suffering, the medical and nursing staff often treated symptoms inadequately because they feared that narcotics would further interfere with respiratory function. Some stood by helplessly, but other nurses prodded the medical staff into action. Finally, all physicians and nurses became convinced that they were obligated to intervene aggressively and treat pain, anxiety, and shortness of breath.

I became principal investigator to study safety on the efficacy of continuous IV morphine in the patient with intractable pain and dyspnea. We formulated a plan to deliver continuous intravenous morphine to those patients for whom all other analgesic regimens have failed.[**] Patients were monitored so that medication would not depress an already compromised respiratory system. Pain was safely relieved as were anxiety and dyspnea. Our head nurse reported the preliminary results at an Oncology Nursing Society meeting. Yes, it was possible, with careful monitoring and titration of medication, to significantly relieve the suffering of these patients. This report was one of 40 publications initiated or aided by 2C North nurses.

2C North is a model nursing unit. In this environment, nurses can develop their full abilities regardless of academic background. They are given the opportunity to develop patient management programs and the flexibility to implement them. Nurses not only give care, they develop better care.

[*] Johnston-Early, Anita, and others. Smoking abstinence and small cell lung cancer: an association. *JAMA* 244:2175-2178, Nov. 14, 1980.

[**] Paper presented at American Society of Clinical Oncology meeting, May 24, 1983.

RESPONSE OF SHARRON DREYER, B.S.N., ASSISTANT ADMINISTRATOR, PATIENT CARE SERVICES, HOSPICE OF NORTHERN VIRGINIA, INC., ARLINGTON, VIRGINIA, TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. Hospice care is reported to result in savings due to the use of fewer ancillary services compared to non-hospice care for the terminally ill. Do you believe such savings are outweighed by increases in cost due to higher staff-to-patient ratios and greater hours of nursing care provided per patient?

Answer 1. The best data we have indicates that in spite of higher staff-patient ratios and greater hours of nursing care, the cost savings in hospice inpatient care are still apparent when compared to non-hospice care for the terminally ill. In a random sample of claims from hospitals for terminal palliative acute care, the local Blue Cross (Group Hospitalization, Inc.) found the average cost in this final admission to be $503 per day. Our cost of $297 per day clearly indicates a substantial cost saving.

Question 2. Would you estimate that the cost of a hospice bed in an inpatient facility is comparable to that of a general medical bed, an intermediate care bed, or a nursing home bed?

Answer 2. See specific figures above. Costs per day for both intermediate care and nursing home care are lower than inpatient hospice care — but staff/patient ratio and hours of nursing care are also considerably lower. Please see pages 4, 5 and 6 of my written testimony for description of inpatient care and patient needs.

Question 3. In your experience, what is the most important component in providing care to the terminally ill?

Answer 3. It is difficult to define the most important component in providing care to the terminally ill. The element of choice in selection of this kind of care certainly needs to be high on the list, and patient and families must understand hospice care in the spectrum of health care options. The other major factor which ranks high needs to be the comprehensiveness of the services and their coordination. Comprehensive means a broad spectrum of services provided in the most appropriate setting to meet individual patient/family needs. Coordination means providing those services in such a manner that avoids both fragmentation and duplication and its resulting imposition of additional stress on patients and families juggling the myriad of issues related to the terminal illness.

RESPONSE OF SHARRON DREYER, B.S.N., ASSISTANT ADMINISTRATOR, PATIENT CARE SERVICES, HOSPICE OF NORTHERN VIRGINIA, INC., ARLINGTON, VA, TO A WRITTEN QUESTION SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question. Please give me your views on the relationship of bereavement counseling to hospice care and, specifically, your views on the extent to which counseling and assistance to the family, both before and after the patient's death, must be an integral part of a hospice-care program.

Answer. Regarding bereavement counseling to veterans' survivors, we certainly support bereavement follow-up for families of veterans receiving hospice care.

In all phases of hospice care, families tend to be more involved than in traditional health-care settings and the patient and family together is defined as the unit of care. Patient and family participate in decisions that are made regarding the patient's care, families are taught skills to enable them to assist in caring for their loved ones. All of this helps prepare the family for the inevitable grief, but they need additional support in rebuilding their sense of independent functioning.

Our experience has shown us that not all survivors require the same degree of assistance and counseling. Telephone contacts, personal visits, individual counseling and/or support groups are provided as part of hospice bereavement follow-up. We believe it is essential to provide this family support through the first anniversary of the patient's death.

Let me summarize by saying that we believe bereavement follow-up for families must be an integral and essential part of a hospice care program.

Mr. PRINCIPI. Finally, our final panel, John Sommer, deputy director, The American Legion; Paul Egan, The American Legion; Phil Mayo, special assistant, Veterans of Foreign Wars; David Gorman, Disabled American Veterans; and Jack Powell of the Paralyzed Veterans of America.

I apologize for the time it has taken and for the chairman's absence and I hope you will proceed. David, I know the chairman was going to welcome you. This is your first appearance before the committee. On behalf of the chairman, welcome.

We will start with Mr. John Sommer.

TESTIMONY OF A PANEL OF REPRESENTATIVES OF VETERANS' ORGANIZATIONS, CONSISTING OF: JOHN F. SOMMER, JR., DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION, ACCOMPANIED BY PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION; PHILIP MAYO, SPECIAL ASSISTANT, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; DAVID W. GORMAN, ASSOCIATE DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND R. JACK POWELL, EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. SOMMER. Thank you, Chief Counsel. The American Legion appreciates this opportunity to appear before the committee to summarize our statement. As requested, we will limit our summary to one issue, and the others are covered in our full statement in detail.

Section 5 of S. 2514 addresses several aspects of the issue of post-traumatic-stress disorder, which is a matter that is of extreme importance to a large number of Vietnam veterans and their families, and has long been a concern of The American Legion.

This measure would establish an associate director for post-traumatic-stress disorder in the mental health and behavioral sciences service of DM&S. This section also sets forth a list of responsibilities appertaining to the position of the associate director, including the development of policy, provision of guidance, and the coordination of the provision of services for the treatment of Vietnam veterans with PTSD.

The American Legion has strongly supported the intent of this section. One very disturbing conclusion drawn from site visit reports prepared by our field representatives and from complaints lodged by American Legion service officers is that in many instances VA physicians have differences of opinion regarding post-traumatic-stress disorder, including the diagnostic criteria and the credibility or even the existence of a PTSD diagnosis.

In addition, we find inconsistencies in the way PTSD is diagnosed and treated within the VA medical care system and in the manner in which PTSD claims are being evaluated by VA regional offices.

Because of these findings the Legion is convinced there is a great need for research, coordination of information and an extensive education of VA health-care professionals regarding the causes, diagnosis and treatment of post-traumatic-stress disorder. And these problems are for the most part addressed in the language contained in section 5.

One immediate concern that we perceive is the need for adequate staff to be assigned to the associate director for PTSD in order to efficiently and effectively carry out the varied tasks that are assigned to that position under this proposal.

Section 12 of S. 2269 as amended directs the Administrator to establish a National Center on Post-Traumatic-Stress Disorder to carry out and promote research into and the training of health-care personnel in the diagnosis and treatment of PTSD and to serve as a resource center for and to promote and to seek to coordinate the exchange of information regarding all research and training activities carried out by VA and other Federal and non-Federal entities, with respect to PTSD.

As previously stated, there is a distinct need for research in this area and a national center on PTSD would appear to provide an appropriate setting for such research to be accomplished. The Legion envisions the results of such research being coordinated and disseminated by the proposed associate director in conjunction with the task force on PTSD and would support such a concept.

Mr. Chief Counsel, subsequent to submitting our full statement to the committee earlier this week, it was brought to my attention that I had not addressed the full intent of S. 2210. Upon reexamining the bill and discovering that it also lifts the bar for transferring an adapted automobile to a family member, we now stand in support of the enactment of that measure. That concludes my remarks.

[The prepared statement of John F. Sommer, Jr., deputy director, National Veterans Affairs and Rehabilitation Commission, The American Legion, follows:]

PREPARED STATEMENT OF JOHN F. SOMMER, JR., DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee:

We appreciate this opportunity to present The American Legion's views on the several legislative matters under the Committee's consideration today, most of which pertain to issues relating to the health care of veterans.

Mr. Chairman, we shall first address -

S. 2514 - "Veterans Health Care Amendments of 1984."

Section 2 of the measure would amend chapter 73 of title 38, United States Code, by establishing a new section to provide that the Administrator shall designate one office in each VA medical care facility and in Central Office to coordinate and arrange for the provision of referral services to assist veterans, as far as possible, in obtaining health services from outside the Veterans Administration, not at VA expense, when such services are reasonably necessary in the treatment of veterans eligible for care under chapter 17 of the title. In carrying out this section, the Administrator is to place particular emphasis on the needs of veterans with service-connected disabilities rated at 50 percent or more and veterans age 65 or older.

The American Legion supports the establishment of such offices as an extension of this organization's support of the legislation that established the community residential care program under section 630 of the title.

With reference to section 3 of the pending measure titled Alcohol Treatment and Rehabilitation, the bill would amend section

620A of title 38, USC, which was created by Public Law 96-22.

The American Legion is supportive of the intent of the proposed section, in that among other things it eliminates the "pilot program" status of the alcohol and drug abuse programs which was the basis on which they were established by PL 96-22. Since the actual efforts to develop meaningful programs for treatment of these disabilities pre-dates PL 96-22, and since it is obvious these disabilities are not going to disappear, we certainly believe such programs should not be conducted by VA on a trial basis. The Department of Medicine and Surgery should know enough about the disabilities by this time to be able to develop effective treatment modalities. Whether it has actually done so, despite its efforts of the past ten years is a question that needs to be answered.

We believe there are alcohol and drug treatment programs now in more than half the VAMCs and Clinics. Our perception is that they are carried on in a decentralized fashion, and we do not see very much evidence of correlation, cooperation and exchange of information among the various programs. It seems to be the case that the physician, or health professional in charge of each individual program develops a treatment modality according to his or her idea of the proper way to treat these conditions. There is apparently no imposition of treatment modalities by Central Office. This is good to the extent that we do not believe Central Office should be telling a doctor how to practice medicine. At the same time, by reason of the nature of these disabilities, and the various treatment programs that have developed in recent years, including the variety now operating in the private sector, it seems to us that many of the program elements have by this time proven to be effective, or conversely, to be ineffective. What is not working should, in our judgment be discontinued system-wide in favor of those elements that have proven to be effective. We believe it is a Central Office function to evaluate the variety of programs and issue treatment guides to do this. If Central Office is issuing such guidance material, we see no evidence of it in our site visits, which now include at least 65 facilities per calendar year.

Another matter that concerns us is the apparent absence of a standarized effectiveness evaluation procedure for the alcohol and drug treatment programs. By this time, more than 10 years since VA became active in the treatment of alcohol and drug abuse disabilities, it should be possible to acquire some idea of how effective this effort has become. We know that thousands of patients have been treated since the overall program began. We realize that effectiveness evaluation for this type of disability is difficult at best. But we also know the recidivism level, system-wide, is not inconsiderable. We know, too, for example that the policy within these treatment programs toward recidivism varies widely.

We of The American Legion certainly do not want to deprive any veteran who needs it of treatment for alcohol or drug abuse. However, we know that the success of any individual treatment of these disabilities depends in great measure on the motivation of the patient toward rehabilitation. The objective of alcohol and drug abuse treatment in our judgment is rehabilitation, as differentiated from maintenance and support. We believe the language of S. 2514 will cause VA to take a closer look at these matters, and hopefully develop both more Central Office coordination of effective treatment modalities and some kind of reliable effectiveness evaluation.

We have some other convictions in regard to alcohol and drug abuse treatment.

We believe, in light of comment offered above in this statement, more Central Office Personnel need to be assigned to this program area. The Table of Organization of DM&S shows only one professional person assigned, which is difficult to understand with reference to one of the major diagnostic entities within the VA health care system.

We strongly believe in the value of halfway houses, particularly in view of the types of patients who populate the VA system, tending to be single, elderly and poor; and so often in need of nutritional and economic support as they adjust to a non-institutional environment. Strengthening the halfway house program, in our opinion is a good idea.

We doubt it is feasible, in statutory language, to define the dimensions of a treatment program, either as to its length or its components. It is necessary, in our judgment, that this must be left to the health professionals.

We do not know whether it can be accomplished by statute, but we believe that in the treatment of alcohol and drug abuse patients, the inclusion of recovered alcoholics and drug abusers on the treatment teams is important. As differentiated from other types of disease and disability, and by reason of the psychological aspect of alcoholism and chronic drug abuse, the presence of recovered substance abusers has a profound effect on those being treated.

We do believe that some controls on recidivism need to be defined and established, whether by statute, which would be difficult, or by treatment guides developed by Central Office. The objective is to avoid non-motivated persons using VA facilities as a temporary refuge. That is not the purpose of alcohol and drug treatment. Where motivation for rehabilitation is not detected, then we would think VA assistance can be provided through the use of the foregoing section 4120 of the title that is proposed by this bill under the heading Referrals And Arrangements For Community Service. There are various ways of determining existence of motivation for rehabilitation, and that cannot be done by statute.

There is also the matter of detoxification, and that is a troublesome problem in the VA system. Presently, some VAMCs will provide detoxing on the medical service. Some provide detoxing on the Substance Abuse Treatment Unit. Some VAMCs will not detox at all, except in cases of medical emergencies. The problem is a legitimate one, because many physicians are not comfortable in depriving a sick patient of a bed that is occupied by someone who is sleeping off intoxication. At the same time, rehabilitation cannot begin until detoxing is accomplished. Our present view is that Medical Services should in all instances retain responsibility for treating medical emergencies involving substance abuse; routine detoxing preliminary to rehabilitation should be done on the Substance Abuse Unit, and for other cases solutions may be found through use of the aforementioned new section 4120 of the title.

Finally, let us say that in the judgment of The American Legion, Congress does in fact have a role to play, not only in providing funding and authorizing staff in the treatment of substance abuse, but also in requiring the agency, at this point to pull together its diverse efforts to deal with this problem; to standarize, at least to a degree, those treatment components so far proven to be effective; and to develop a methodology to measure the effectiveness of the still expanding effort to deal with a serious national health problem that affects veterans as it does all elements of society.

Section 4 of this measure would amend section 601(6)(A)(i) of the title by including "devices for the hearing impaired in the case of any veteran who is totally deaf (including telecaptioning television decoders)" under definition of the term "medical services," as it applies to chapter 17 of the title.

The American Legion would offer no objection to this proposal.

Section 5 of S. 2514 addresses several aspects of the issue of post-traumatic stress disorder, a matter that is of extreme importance to a large number of Vietnam veterans and their families, and has long been a concern of The American Legion.

The measure would establish an Associate Director for Post-Traumatic Stress Disorder in the Mental Health and Behavioral Sciences Service of DM&S. This section also sets forth a list of responsibilities appertaining to the position of Associate Director, including the development of policy, provision of guidance, and coordination of the provision of services for the treatment of Vietnam veterans with PTSD.

The individual appointed to this position shall coordinate, by medical region, inpatient care for eligible veterans suffering from PTSD, and shall take steps to ensure that the provision of such care includes the use of treatment plans, referral procedures, and post-treatment follow-up care.

The Associate Director shall also be given the responsibility of conducting special education and training programs on PTSD for appropriate employees of the Department of Medicine and Surgery, including programs on diagnostic criteria and methodologies, referrals, and the formulation and implementation of treatment plans and follow-up care.

Section 5 further states that the Chief Medical Director shall establish a task force on the care and treatment of post-traumatic stress disorder. The task force would include health care employees of VA who are involved in the treatment and care of veterans suffering from PTSD. And the task force is to advise the Chief Medical Director on policies regarding the following:

(A) The use of appropriate treatment modalities and the devlopment of standards governing lengths of stay of veterans in VA health care facilities for care and treatment of problems related to PTSD;

(B) the coordination of treatment of PTSD patients after discharge from inpatient care;

(C) the monitoring and evaluation of treatment programs for PTSD patients;

(D) the conduct of health services research making comparisons among various treatment modalities for PTSD to determine proper treatment methods and length of stay;

(E) ensuring proper diagnosis of PTSD at all medical facilities including those which do not have programs dedicated specifically to the care and treatment of PTSD; and

(F) the necessity of, and appropriate standards governing referral of patients, including those receiving vocational rehabilitation in domiciliaries.

According to the measure, not later than nine months after the date of enactment, the Administrator shall submit to the Committees on Veterans Affairs of the Senate and House of Representatives a report evaluating the results of the implementation of this new subsection of the title.

Mr. Chairman, The American Legion is, in general, strongly supportive of the intent of section 5 of S. 2514. One very disturbing conclusion drawn from site visit reports prepared by our Field Representatives, and from complaints lodged by American Legion Service Officers is that many VA physicians have differences of opinion regarding post-traumatic stress disorder, including the diagnostic criteria, and the credibility or even the existence of a PTSD diagnosis. In addition, we find inconsistencies in the way PTSD is diagnosed and treated within the VA medical care system, and in the manner in which PTSD claims are being evaluated by VA regional offices.

Because of these findings, the Legion is convinced there is a great need for research, coordination of information, and an extensive education of VA health-care professionals regarding the causes, diagnosis and treatment of post-traumatic stress disorder. And these problems are for the most part addressed in the language contained in section 5. One immediate concern that we perceive is the need for adequate staff to be assigned to the Associate Director for PTSD in order to efficiently and effectively carry out the varied tasks assigned to that position under this proposal.

Mr. Chairman, a majority of Vietnam veterans seemingly made a successful transition from the hostilities of combat, back into civilian society. It was discovered early on that others were undergoing serious readjustment difficulties brought on by post-traumatic stress disorder and other physical and psychological problems. It has only been recently found that a significant number of the Vietnam veterans who had appeared to have made a rapid readjustment are now manifesting symptoms of PTSD in varying degrees. Examples are difficulty maintaining employment as they cannot remain on any one job for any length of time; problems in sustaining interpersonal relationships, including intimacy problems, because of an inability to trust or get close to a spouse, partner or friends; sleep disturbance, memory impairment, negative self-image, and other delayed reactions attributable at least in part to their military experience.

Experts in the diagnosis and treatment of PTSD estimate that between 30 and 60 percent of all combat veterans of Vietnam, plus additional non-combat veterans such as a number of hospital and graves registration personnel are suffering at least some symptoms of the disorder. Our feeling is that the percentage of combat veterans affected is probably closer to the higher end of the scale based upon the pre-test of the Columbia University and American Legion Study of Vietnam Era Veterans. The pre-test findings on the actual incidence of post-traumatic stress disorder led to an adjustment in the number of questions relating to PTSD on the questionnaire that is being used in the full study.

The problems relating to the manner in which the Veterans Administration has been handling the issue of post-traumatic stress disorder are extremely disconcerting to The American Legion, with respect to the aforementioned inconsistencies in the diagnosis and provision of treatment at VA medical centers, and the adjudication of claims in the regional offices.

The American Legion has found that there are a variety of problems associated with the adjudication of PTSD claims. Some relate to a lack of documentation of the "stressors" of duty in Vietnam. There is the problem of psychiatric examinations that are less than adequate and the subsequent negative impact on ratings based on such examinations. And there are problems resulting from the attitudes of some VA personnel.

As for documentation of information relating to an individual's experiences in Vietnam, the veteran, upon application for service connection, may make statements concerning incidents or experiences occurring many years past. Generally, it is difficult to provide any type of corroborating documentation with the exception of a combat award such as a Purple Heart, Combat Infantry Badge, Combat Medical Badge, or an award for valor. A rating examination must be based on a history related by the veteran which may or may not be voluntarily provided. This puts such a claim at a definite disadvantage, since some examining physicians are not sufficiently familiar with military activities in Vietnam to elicit all of the necessary information, particularly, in the case of veterans who are reluctant to discuss their combat experiences. Thus, the resulting diagnosis, in many instances, does not adequately reflect the onset or evolution of the veteran's current condition.

In this regard, the Veterans Administration has an obligation and responsibility to undertake development and confirmation of certain information relating to the individual's military service. VA, however, has not fully taken the initiative in this situation. The American Legion is pleased that the Army Agent Orange Task Force has agreed to take responsibility for conducting research of military records to document PTSD claims in response to requests for information from veterans, accredited representatives or VA. We have found the AAOTF to be responsive and cooperative. Unfortunately, their staffing is limited and the research is very time consuming. However, without the information that the AAOTF can often provide, many claims are denied due to a "lack of a demonstrated stressor in Vietnam."

With respect to inadequate rating examinations, the Legion has all too often been confronted with diagnoses of personality disorder or anti-social personality, with no finding of PTSD. Many times we have found that no military history was elicited from the veteran during the examination and although the veteran exhibits symptoms such as recurrent dreams about being killed in Vietnam, survival guilt, startle response, limited social or interpersonal relationships, etc., etc., the examining physician arbitrarily states that there is no evidence to support a diagnosis of PTSD.

It is also apparent that some examinations are conducted by individuals who are unfamiliar with the information needed to rate the case. Certain facts may not be included in the examination report, either out of a lack of understanding of the adjudication process or a conscious decision that not everything related by the veteran is important to his case. Unless further training, communication and coordination between the Department of Veterans Benefits and the Department of Medicine and Surgery is undertaken, many claims will continue to receive incomplete examinations resulting in premature denials.

The American Legion has found the adjudication of PTSD claims to be extraordinarily stringent in a significant number of cases. This is also substantiated by comments we are receiving from psychiatrists and psychologists at some VA medical centers.

While The American Legion is aware that problems do not exist in every medical center or regional office, it is disturbing to know that any Vietnam veteran is not receiving fair and equitable treatment by the Veterans Administration. And the Legion will not tolerate employees of the Veterans Administration who unilaterally decide that PTSD is not a valid diagnosis. That issue has been settled and appropriate directives have been issued. Any VA employees who will not or cannot accept it should not be in VA service.

Mr. Chairman, The American Legion will continue to monitor all activities relating to the handling of post-traumatic stress disorder by both VA medical care facilities and the regional offices. We insist that these Vietnam veterans who continue to bear the burdens of their war service, are to be treated compassionately and objectively in their quest for answers and solutions to their readjustment problems.

Section 6 of S. 2514 provides that not later than September 30, 1985, the Administrator shall submit to the Committees on Veterans Affairs a report regarding VA programs (1) to furnish palliative and supportive care to terminally ill veterans and supportive care to members of such veterans' families, and (2) to furnish care to terminally and chronically ill veterans for brief periods in part for the purpose of providing a respite for members of the veterans' families in order to encourage them to maintain the veterans in their homes, in order to obviate the need for institutional care, to the maximum extent possible. This section also sets forth specific informatio that is to be included in the report, to include proposals for such administrative or legislative action as the Administrator may deem appropriate in light of the findings and conclusions of the report.

The American Legion fully supports the intent of this section. The Legion has consistently advocated the importance and desirability of maintaining chronically and terminally ill veterans in their community or home environment to the fullest extent possible.

Mr. Chairman, we shall now address -

S. 2269 - "Veterans' Administration Health-Care Program Improvements Act of 1984," and Amendment No. 2850 appertaining thereto.

Section 3 of the measure would amend section 601(6)(B) of the title by providing extended eligibility for mental health counseling and related services to those family members receiving counseling, along with the veteran, at the time of the veteran's death. The proposal would authorize VA to continue, for up to six months following the death of the veteran, to provide appropriate mental health assistance to the family members, and The American Legion supports such an extension.

Section 4 of S. 2269 would amend section 612A of the title by expanding the eligibility criteria for the provision of readjustment counseling.

This section would make eligible for readjustment counseling services those current members of the Armed Forces, who also served on active duty during the Vietnam conflict. In addition, it would provide eligibility for these services to individuals who served in the Armed Forces after the Vietnam Era, and who were subjected to danger from armed conflict comparable to the danger to which members of the Armed Forces have been subjected in combat during a period of war.

The American Legion views favorably the provision of readjustment counseling to those persons serving on active duty who also served in Vietnam. As far as we have been able to determine, there are no readjustment counseling services available in military medical facilities to address problems related to post-traumatic stress disorder. Perhaps more importantly, if such counseling programs were available, through the military, it is unlikely that many individuals on active duty would seek assistance from them. Most veterans of Vietnam who have continued their military service are career-oriented senior enlisted personnel and officers who would not jeopardize their future advancement by submitting themselves for treatment of any condition that could be construed as "psychiatric" in their service medical records.

Likewise, we would not object to the extension of eligibility for readjustment counseling to those individuals in service during periods of time and in specific locations in which U.S. Armed Forces were engaged in combat. There is no doubt that the Marines in Beirut, and many of the Army, Navy, Air Force and Marine Corps personnel involved in the invasion of Granada were faced with life-threatening incidents - the precursor of PTSD. Unlike the situation that existed when veterans were returning from Vietnam, much more is now known about the causes, effects, diagnosis and treatment of PTSD. We would hope that the latest group of American troops involved in combat were provided a period of desensitization or decompression, much like that provided the American hostages upon their release from Iran. A program of this nature should alleviate future problems for many of these military personnel.

Section 5 of this measure would amend section 620A of title 38 by making permanent the program for the treatment and rehabilitation for alcohol or drug dependence or abuse disabilities, as it is currently a pilot program.

The American Legion supports the intent of this provision. Our position on the VA Alcohol and Drug Treatment program is set forth earlier in this statement.

Section 6, as amended by Amendment No. 2850, is intended to improve the ability of the Veterans Administration in recruiting and retaining protective service personnel; require regulations for

VA police officers' authority to make arrests, define their authority to make arrests; and to provide increases in uniform allowances.

The provision of this section dealing with salary increases would allow the Administrator to apply for special salary rate increases for VA police officers on a nationwide, local, or other geographic basis, for one or more of the grades ....., etc., as is currently applicable to health care personnel. Although this would appear to be a partial answer to the long-standing recruitment and retention problems associated with the VA Security Service, The American Legion does not feel that special salary rate increases would provide a solution to the chronic deterioration resulting from a lack of stability within the Security Service. Requests for special increases would be left up to local VA medical center directors, many of whom would not submit such a request. In addition, there are documented cases where special salary rate increases have been authorized, eventually eliminating recruitment problems, and then were withdrawn because recruitment problems suddenly did not exist anymore. The American Legion continues to support a system-wide increase in salary grades for Security Service personnel.

We strongly endorse the proposed increase in clothing or uniform allowances. This is another one of the major complaints our office receives from VA security personnel.

The Legion is in agreement with the provisions that provide the Administrator with the authority to prescribe regulations to affix penalties for violations of various regulations, and to authorize VA police to enforce laws and regulations and to make arrests.

With respect to the issue of training, it is the opinion of The American Legion, based on information gathered through site visits, and conversations and correspondence with VA security personnel, that the training currently provided at the Little Rock facility is grossly inadequate. There needs to be either an expansion of this training period, or implementation of alternative training, possibly in the form of periodic training sessions within each Medical Region.

Admittedly, a problem exists in regard to the issue of weapons for VA police officers, and The American Legion recognizes it to be a severe one. However, we believe that firearms in a health care environment can only spell trouble for all concerned. Records reviewed show an annual average of 85 incidents involving the use of the non-lethal Chemical Irritant Projector (CIP) weapon. While we recognize the shortcomings associated with the CIP weapon, such as its ineffectiveness on some individuals under the influence of alcohol and/or drugs, we also must weigh the consequences of utilization of a deadly weapon. There are those rare occasions where possession of a firearm would be warranted, but we believe that fundamentally it is the responsibility of local police and other Federal law enforcement agencies to assist VA in matters of this kind. We would suggest efforts be undertaken with these agencies to strengthen rapport levels and improve response times.

Section 7 of S. 2269 would amend the due date of a recurring Comptroller General's report on the Director of the Office of Management and Budget's compliance with statutory requirements relating to funded personnel ceilings for the VA's Department of Medicine and Surgery.

The Legion has no objection to this amendment.

Section 8 of this measure would amend section 5035 of the title to require the Administrator to prescribe regulations setting forth criteria by which grant applications for construction, remodeling or renovation of State veterans homes would be rated and, in any year in which the value of approvable grants exceeds the funds appropriated for such purposes, to award such grants in accordance with the priority assigned. The priority would be required to take into account, among other things, the demand on the VA for nursing home and domiciliary care in the geographic area concerned and the extent to which it is feasible and desirable to meet that demand through various VA authorities.

The American Legion feels that the current criteria for VA funding of construction, remodeling and renovation of State homes is adequate, and the manner in which such projects are funded is equitable and fair. Therefore, we do not support the intent of this section.

Section 9 would require the Administrator, in conjunction with the Secretaries of Defense and Health and Human Services to submit a report to the Congress advising on how the Federal Government might respond to the needs of individuals who served in the Republic of Vietnam during the Vietnam era as employees of the U.S. Government, or organizations officially determined to have provided significant assistance to the U.S. Armed Forces in RVN, with respect to health problems that might be related to exposure to Agent Orange or to particularly stressful combat situations. The joint report is to be submitted to the appropriate committees of Congress within 180 days of enactment, and is to contain various alternative approaches, along with comments on the appropriateness and the advantages and disadvantages of each, and any official recommendations for legislative and administrative action for establishing a program for providing such benefits, services and assistance to these individuals.

The American Legion would support the intent of this provision.

Section 10 amends section 601(4)(C)(v) of the title so as to extend the authority for providing contract medical care to veterans in Puerto Rico and the Virgin Islands until September 30, 1985, and the Legion supports this extension.

Section 11 would amend section 618 of title 38 by adding a new subsection stating that notwithstanding any other provision of law, no amount of remuneration provided to an individual as a participant in a therapeutic or rehabilitative activity carried out pursuant to this section shall be included in determining annual income for purposes of pension payments.

Mr. Chairman, The American Legion strongly endorses the purpose of this section. The Department of Medicine and Surgery has in its rehabilitation procedures a number of programs in the category of incentive therapy or rehabilitative therapy, in which disabled and hospitalized veterans perform compensated work of a nature that is within the capability of their physical limitations. The work is accomplished under medical management and the programs have proven therapeutic value for the veterans who participate. The programs provide veterans with a measure of dignity and the compensation paid them is below the minimum wage. However, it has recently been determined that the modest remuneration received from such programs is to be counted for pension purposes. This has resulted in a number of overpayments in the case of veterans receiving nonservice-connected disability pension; and the withdrawal from such programs by many veterans because of the requirement to count the minimal amount of compensation as income.

The American Legion feels that this not only defeats the purposes of ongoing medical therapy and rehabilitative processes, but also demonstrates a lack of understanding of the genuine purposes of these programs. Therefore, at its meeting of February 29, 1984, the National Veterans Affairs and Rehabilitation Commission of the Legion adopted a resolution calling for the organization to sponsor and support legislation identical to the intent of this section. The resolution will be acted upon by the National Executive Committee during its meeting May 9-10.

Section 12 directs the Administrator to establish a national center on post-traumatic stress disorder to (1) carry out and promote research into, and the training of health-care personnel in the diagnosis and treatment of PTSD, and (2) to serve as a resource center for and to promote and to seek to coordinate the exchange of information regarding all research and training activities carried out by VA, and by other Federal and non-Federal entities, with respect to PTSD.

In addition, this section would direct the Administrator to submit to the Committees on Veterans Affairs, within 90 days after enactment, a report containing a description of the steps taken and plans made, including a timetable, to establish such a center. The report would also contain (1) the assessment of the Chief Medical Director regarding the capability of VA to provide inpatient and outpatient PTSD diagnosis and treatment (both through PTSD inpatient treatment units and otherwise), as well as a description of the results of any evaluations that have been made of existing PTSD inpatient treatment units, (2) any recommendations and a description of any activities planned for improving such diagnoses and treatment and for correcting any deficiencies in the operations of such units, and (3) the Administrator's assessment of the capacity of the VA to meet the need for PTSD diagnosis and treatment in all geographic areas of the United States and any plans and timetable for increasing that capacity, including the costs of such action.

Mr. Chairman, we expressed our concerns about the problems surrounding the issue of PTSD diagnosis and treatment earlier in this statement, in support of the establishment of the position of Associate Director for PTSD within DM&S and other related provisions. As previously stated, there is a distinct need for research in this area, and a national center on PTSD would appear to provide an appropriate setting for such research to be accomplished. The Legion envisions the results of such research being coordinated and disseminated by the proposed Associate Director in conjunction with the task force on PTSD, and would support such a concept.

Mr. Chairman, S. 2210 would amend section 1903(c) of the title to provide that an eligible person shall not be entitled to automobile adaptive equipment under chapter 39, for more than one automobile or other conveyance in a three year period, except where the Administrator determines, according to standards which the Administrator shall prescribe, that exigent circumstances justify early vehicle replacement.

The American Legion feels that the limitations set forth in this bill could prove to be unduly restrictive to a small group of severely disabled veterans and, therefore, we do not support its enactment.

S. 2278 - provides that the Administrator in furnishing hospital, nursing home, and domiciliary care and medical and rehabilitative services, may contract for such care and services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities for eligible veterans suffering from alcohol or drug dependence or abuse disabilities. In addition, it would amend section 620A of title 38 by placing the pilot program for the treatment and rehabilitation for alcohol or drug dependence or abuse disabilities into the category of a permanent program.

We previously set forth the Legion's views on the Alcohol and Drug Treatment program, and would not object to the intent of this measure.

Mr. Chairman, that concludes our statement.

Mr. MAYO. Thank you, Mr. Chief Counsel. It is a pleasure for us to be before you today and present our views on a number of legislative proposals to improve health care for veterans, among other things. We support the thrust of the majority of the legislation before the committee. Our observations in that connection have been outlined in our prepared statement for your review.

In our statement, however, we oppose the enactment of S. 2210, introduced by the chairman. In light of our further review of the bill, we have determined that its provisions contain improvements in the adaptive equipment program that we wish to see enacted. That is a veteran may own more than one such adaptive conveyance at one time.

We believe the language in the bill will reasonably accommodate exceptions for such as accidents or exceptions for high mileage to the one car in 3-years rule. Therefore, we support its passage.

That concludes my summary.

Mr. PRINCIPI. Thank you.

[The prepared statement of Philip R. Mayo, special assistant, National Legislative Service, Veterans of Foreign Wars of the United States, follows:]

VETERANS OF FOREIGN WARS OF THE UNITED STATES

PREPARED STATEMENT OF

PHILIP R. MAYO, SPECIAL ASSISTANT
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE

WITH RESPECT TO

LEGISLATION TO IMPROVE HEALTH CARE FOR VETERANS

WASHINGTON, DC APRIL 11, 1984

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for the opportunity to come before you to present, on behalf of our 1.97 million members, our views with respect to a number of legislative proposals to improve the health care provided veterans by the Veterans Administration.

Mr. Chairman, we would like to begin by commending you and all members of the Committee for their foresight in advancing into law of what is now Public Law 98-160, the "Veteran's Health Care Amendments of 1983," some of the provisions of which may be further improved by the legislation before the Committee today.

Mr. Chairman, the first item we would like to address in our remarks is the matter of the pilot contract program for drug and alcohol treatment within the VA. Provisions of three measures (S.2269, S.2278, S.2514) before the Committee today would affect the status of that program, which is due to expire on September 30, 1985. As you know, the VA was to have reported to the Congress on various aspects of this program on March 31, 1984, and we are informed that the report will be forthcoming at a later date.

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Even though informal information indicates many positive experiences from the operation of this effort, and inasmuch as it is due to expire next year, we prefer to render our views on the legislation subsequent to the availability of the report and the opportunity for us to evaluate its findings. We therefore request the Committee's forebearance in this connection.

The first measure, S.2514, introduced by the Chairman of the Committee, the Honorable Alan Simpson, would authorize the Veterans Administration to arrange for certain health and health-related services in local communities at no expense to the VA, but which would allow the VA to further manage a veteran's care.

Mr. Chairman, we support what the intent of this provision would accomplish as described in your remarks in the Congressional Record. However, that intention, in our view, is not adequately conveyed in the legislative language. The use of the term "not at Veterans Administration expense" with respect to such provision of treatment, followed by the requirement that "particular emphasis on the needs of veterans with service-connected disabilities rated at 50 percent or more and veterans age 65 or older" appears to provide that those who are currently statutorily eligible for such care at VA expense may be required to provide such at their own or community expense — thereby creating the impression of "mainstreaming." We believe, as we are sure you do, that those eligible should be able to have such care whether or not an expense is incurred by the VA if such is incidental to the best care available for the veteran, particularly when such would obviate the need for institutionalization of the veteran. Accordingly, language that provides broader authority for VA to cooperate with the community for such purposes would be desirable, we believe, and has our support. Likewise, we believe this is the intent of this provision of the bill.

Another provision of the bill would authorize the Administrator to provide to veterans who are totally deaf telecaptioning television decoders. We support the enactment of this inasmuch as we believe the current practices with respect to such devices are too stringently interpreted.

Mr. Chairman, S.2514 further provides that the Administrator shall establish the position of Associate Director for Post Traumatic Stress Disorder in order to develop VA policy, provide guidance, and coordinate care for Vietnam veterans suffering from PTSD. This same section also provides that the Chief Medical Director shall establish a task force on the care and treatment of PTSD. The task force would advise the Chief Medical Director on treatment modalities, post treatment follow-up on patients; monitoring and evaluation of treatment programs, conduct of health services research; ensuring proper diagnosis of PTSD at all medical facilities; appropriate standards for referrals of patients, and to report to the Congress on such within nine months of the enactment of the measure.

We agree with the substance of this section of the bill that greater coordination among PTSD unit efforts is warranted. However, we do not believe the position to accomplish such and the duties of the position should be specified in legislation. We believe the task force prescribed in this section would be the appropriate vehicle to develop such. Accordingly, we support the intent of establishing improved coordination in this program, and we specifically support the establishment of the task force along with its mission. We would also suggest that treatment not be restricted to Vietnam veterans; that the commitment of needed human and physical resources in PTSD units would provide great impetus insofar as attaining the goals hoped for under this section of the bill.

The sixth section of the bill would direct the Administrator to submit a report to Congress regarding VA hospice and respite programs for terminally and chronically ill veterans. We have no objection to the VA providing such information to the Congress within the limits of its experience and expertise. We are not aware of authority to conduct a respite care program being given the VA. However, we support such an undertaking and the subsequent reporting thereon by the VA.

The second initiative before the Committee today is S.2269, introduced by the Ranking Minority Member of the Committee, the Honorable Alan Cranston. Mr. Chairman, we support the establishing of dates of the Vietnam era as (for Title 38 purposes) July 8, 1959 through May 7, 1975 as provided in the bill. As you know, we suggested to the Committee, during hearings last year, that the initial date of July 1, 1958 be used inasmuch as that date is coincidental to the date of the award of the Armed Forces Expeditionary Medal for service in Vietnam. Additionally, those who are currently in the active military who are Vietnam-era veterans would be made eligible for readjustment counseling. We support this provision of the bill and recommend that where the VA provides such services that it be accomplished under the provisions of Public Law 97-174, the Veteran's Administration and Department of Defense Health Resources Sharing and Emergency Operations Act, as a reimbursable admission.

Thirdly, S.2269 provides the Administrator, in consultation with the Secretary of Defense, with the authority to specify periods of service occurring subsequent to the Vietnam-era and certain geographical locations in which Armed Forces personnel were under hostile fire and eligibility for readjustment counseling would be warranted. We support this provision of the bill on the same basis as that in the preceding paragraph. We are aware, Mr. Chairman, that such services would be beneficial to a number of those who have served in Grenada and Lebanon; that there are participants of those actions who have sought such assistance as a result of their service.

Another provision of the bill would, for up to six months, authorize on an outpatient basis, bereavement counseling for family members of veterans who are undergoing a program of readjustment counseling and who die during the course of that program. Similar counseling would be authorized for family members of veterans who are terminally ill where the VA is providing care, such as hospice care. Mr. Chairman, we support enactment of this provision in that we are aware of a number of cases in which the availability of such would have been very beneficial.

Another provision of S.2269 would require the Administrator to prescribe new regulations for the allocation of funds under the State home facility grant program that would take into account, among other factors, the demand for such care in the geographic area and the extent to which it would be feasible to provide such care through VA or other non-state home facilities. It is our understanding that the present mode of reviewing requests for grants establishes the need for the particular project both by the VA and the state in question, and we have received no criticisms concerning determinations made in that connection other than there exist insufficient appropriated funds to meet the demand for grants. Information also available to us indicates general satisfaction with the way this program operates; therefore we would not concur in the changes suggested in S.2269.

Additionally, provisions of S.2269 would require the Administrator, within 180 days after the date of enactment of this measure, to report to the Congress, in conjunction with the Secretaries of Defense and of Health and Human Services, on how the Federal Government might respond to the needs of individuals who served in Vietnam in Federal civilian capacities and as employees of such organizations as the American Red Cross and the USO. These individuals, by virtue of their service, may be suffering from problems related to exposure to dioxin or their involvement in particularly stressful combat situations. Mr. Chairman, we agree that these individuals may suffer from similar problems as those who served in the military in that theater; we concur that the VA may be able to provide insight into the resolution of those problems; that the VA's involvement in such a dialogue would be helpful in determining a means whereby various resources may be applied toward their resolution. However, we would be opposed to the use of VA resources toward their resolution. As valuable as these individuals were in our efforts in Vietnam, the fact remains that they are not veterans.

Mr. Chairman, further provisions of S.2269 are before the Committee in the form of amendment number 2850, again offered by the Ranking Minority Member of the Committee. The first of those is concerned with the enhancing of the ability of VA protective police to accomplish their mission and to provide for improved recruitment and retention authority for those police. The measure provides the Administrator with broad authority, in conjunction with the Attorney General, to determine penalties, law enforcement, and arrest regulations; the scope and duration of training for such police rules limiting the carrying and use of weapons; uniform allowances; and increased rates of basic pay when necessary. Mr. Chairman, the problems this measure addresses have been well documented by the VFW and others in testimony on numerous occasions. We endorse this provision, but encourage the Committee to pay particular attention to the scope of the provisions concerning the carrying and use of weapons. We are opposed to the general carrying of firearms, and believe that their use should be restricted to extreme cases such as those dealing in drug arrests and the like.

Another provision of the amendment would authorize contract care in Puerto Rico and the Virgin Islands for another year, and we support this provision.

The amendment also provides that remuneration received by veterans who are in receipt of non-service connected pension payments and who are involved in VA-sponsored programs of incentive work therapy would not be counted as income for pension purposes. We have recommended such to the Administrator, who has expressed his concurrence in our views. We believe the inclusion of such income for pension purposes would go a long way toward discouraging veterans from undergoing this type of treatment program, and, accordingly, we support the enactment of this provision.

The final provision of the amendment would authorize the formation of a national center on Post-Traumatic Stress Disorder (PTSD) within the VA to carry out and promote research into, and the training of health care personnel in the diagnosis and treatment of PTSD as well as being a resource center to promote the exchange of information regarding research and training by others in the area.

Mr. Chairman, we believe this relatively new, separate diagnostic category to be a very dynamic one. While the formation of such a center may be very desirable at some point, we believe, on the basis of the best information available to us from those professionals active in this field, that the intensive "hands-on" type treatment required to both diagnose and treat this particular disorder suggests that the commitment of human and physical resources to achieve greater formalization of these units in the VA and a more formal means of support for the units from VA Central Office should take precedence. More is learned about this phenomenon from direct diagnosis/treatment involvement with veterans than from other means, and the addition of the resources to accomplish this end, we believe, should be the first priority.

The last measure under consideration, S.2210, introduced by the Chairman, proposes to revise and clarify the eligibility of certain veterans to receive automobile adaptive equipment by restricting such to no more than one automobile or other conveyance every three years, except in certain exigent cases.

Mr. Chairman, we oppose the enactment of this legislation. It reduces current entitlements to affected veterans, and, further, the best information available to us indicates there is insufficient basis to warrant such legislation. We are not aware of abuses that would warrant such; we believe that 75 percent of average cost of such vehicles is borne by the veteran, and we are not convinced that any substantial cost-savings would accrue to the VA should this measure be enacted.

Mr. Chairman, this concludes my testimony.

Mr. **Principi**. Mr. Gorman.

Mr. **Gorman**. Thank you, Mr. Chief Counsel. I also, as requested, will summarize the text of our complete testimony, which is in the record. Introduced by the chairman of the committee during January of this year, S. 2210 proposes, through an appropriate amendment to section 1903(c) to title 38, to provide adaptive equipment to an eligible veteran for one automobile or other conveyance in a 3-year period.

However, there are provisions in that bill that would allow the Administrator when he determines exigent circumstances exist that would justify early vehicle replacement to do just that.

As we understand the language and intent, this measure would remove the prohibition which currently exists, as determined by the General Counsel, to preclude an eligible veteran from receiving reimbursement for adaptive equipment on a subsequently purchased vehicle, while the same veteran retains title to a previously purchased automobile so equipped.

In this respect, it is important to note that the VA's program of reimbursement for adaptive equipment on the purchase of a new vehicle covers only a small fraction of the total cost of the vehicle and its monetary obligation that has been incurred by the eligible veteran. As such a vested interest is incurred based on personal monetary outlays by the veteran. At the time of divesting ownership of the vehicle, latitude should exist to allow the veteran to receive the most advantageous return for the initial monetary investment.

Current law prohibits this and in doing so the VA dictates the method in which disposal of the vehicle would have to be achieved.

We therefore, in our view of the intent of the purpose of S. 2210 in permitting a veteran to retain title and/or ownership of a previously adapted vehicle and still be eligible for reimbursement for a subsequently purchased vehicle, so long as he has owned the previous vehicle for at least 3 years, certainly support the enactment of S. 2210.

Section 4 of S. 2514 proposes to amend chapter 17 of title 38, to provide the VA with statutory authority to provide devices for the hearing impaired in the case of any veteran who is totally deaf, including telecaptioning television decoders. This measure is necessary in our opinion, again, in view of a VA General Counsel opinion which reached the conclusion that there was no existing legal authority to provide telecaption decoders.

Only through this device is the user able to regain a small semblance of normal, everyday communication that everyone is entitled to and which the nonhearing impaired often take for granted. If there is a means to produce a more meaningful and productive lifestyle, which we feel there is in this instance, then it should be utilized by and not denied to the disabled veteran.

Mr. Chief Counsel, during the course of our dealings with members of the hearing impaired community, we have been informed that the term "profoundly deaf" is preferable to the term "totally deaf." Therefore, as a suggestion, should this measure be favorably reported, we would suggest that the terminology used to describe the degree of hearing loss—profoundly versus totally—should be considered by the committee.

That concludes my summary.

Mr. PRINCIPI. Thank you.

[The prepared statement of David W. Gorman, associate deputy national legislative director, Disabled American Veterans, follows:]

PREPARED STATEMENT OF DAVID W. GORMAN, ASSOCIATE DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than 856,000 members of the Disabled American Veterans, I want to thank you and the members of the Committee for allowing us this opportunity to appear here today and relate our views on various bills pertaining to the Veterans Administration health care system.

Mr. Chairman, due to the fact that the various measures introduced--S. 2210, a bill to revise and clarify the eligibility of certain disabled veterans for automobile adaptive equipment; S. 2269, the "Veterans Administration Health-Care Program Improvements Act of 1984"; S. Amendment No. 2850 to S. 2269; S. 2278, the proposed "Care for Chemically Dependent Veterans' Act"; and S. 2514, the "Veterans Administration Health Care Amendments of 1984"--have certain similarities and are common in subject matter, our testimony will address each bill by subject matter contained therein as opposed to each bill separately.

AUTOMOBILE ADAPTIVE EQUIPMENT

Introduced on January 24, 1984, by you, Mr. Chairman, S. 2210 proposes, through appropriate amendment to Section 1903(c), Title 38, United States Code, to provide adaptive equipment to an eligible veteran for one automobile or other conveyance in a three year period, except where the Administrator determines that exigent circumstances justify early vehicle replacement.

Mr. Chairman, as we understand it, the language and intent of this measure would, in effect, substantially alter two major aspects of the VA's current policy regarding the Adaptive Equipment Program. First, the policy of providing reimbursement for a replacement vehicle for three vehicles in a two year period would be terminated. Second, the prohibition which currently exists--as determined by VA General Counsel--that precludes an eligible veteran from receiving reimbursement for adaptive equipment on a subsequently purchased vehicle, while the veteran retains title to a previously purchased automobile so equipped, would be removed.

Simply stated, Mr. Chairman, under current law, should an eligible veteran purchase, for whatever reason, a new automobile, he/she must first dispose, outside of the family or the immediate household, the previously adapted vehicle before entitlement to reimbursement for adaptive equipment on the most recently acquired vehicle can occur.

It has always been the DAV's position that this prohibition is discriminatory to the veteran.

It is important to note that the VA's reimbursement for adaptive equipment on the purchase of a new vehicle covers only a fraction of its total cost and monetary obligation that is incurred by the eligible veteran. As such, a vested interest is incurred based on personal monetary outlays by the veteran. At the time of divesting ownership of the vehicle, latitude should exist to allow the veteran to receive the most advantageous return for the initial monetary investment. Current law prohibits this and, in doing so, the VA dictates the method in which disposal of the vehicle must be achieved.

We view the intent of S. 2210 as permitting a veteran to retain title and/or ownership of a previously adapted vehicle and still be eligible for reimbursement for a subsequently purchased vehicle, so long as the veteran has owned the previous vehicle for at least three years.

In accordance with the goal of a resolution approved by the delegates to our most recent National Convention, the DAV supports the enactment of S. 2210.

TELECAPTIONING TELEVISION DECODERS

S. 2514 proposes to amend Chapter 17, Title 38, United States Code, to provide the VA with statutory authority to provide "devices for the hearing impaired in the case of any veteran who is totally deaf (including telecaptioning television decoders)."

As you are aware, Mr. Chairman, the DAV has been involved in various efforts to improve the benefits provided by the Veterans Administration to the service-connected hearing impaired veteran. These efforts have included conducting a Hearing Loss Survey, via DAV Magazine, January, 1983, to attempt to determine the problems and needs of hearing impaired veterans. The extent of the response to that survey was beyond our expectations. During October, 1983, we conducted a Hearing Loss Symposium at our Washington, DC Headquarters. Participants and invitees included VA officials, professionals in the field of deafness, hearing impaired consumer groups and members of the Senate and House Veterans Affairs Committees.

Mr. Chairman, positive steps have already been witnessed from these efforts. I am referring, of course, to the report language that accompanied the passage of S. 1388 which later became Public Law 98-223, wherein the VA has been directed to conduct a study of the various factors involving hearing loss.

Mr. Chairman, the pending legislation is indeed necessary in view of a VA General Counsel Opinion which reached the conclusion that there is no existing legal authority to provide telecaption decoders.

That Opinion stated telecaption TV decoders were considered "an item of psycho-social value, (and) to make life outside a health care facility more comfortable."

We do not think this to be the case. Rather, a telecaption TV decoder serves as the only feasible means available to a profoundly deaf veteran to experience the real value offered from the media of TV.

Only through this device is the user able to regain a small semblance of normal, everyday communication that everyone is entitled to and which the non-hearing impaired often take for granted. If there is a means to produce a more meaningful and productive lifestyle, which there is in this instance, then it should be utilized by and not denied to the disabled veteran.

Mr. Chairman, one additional point:

During the course of our dealings with members of the hearing impaired community, we have been informed that the term "profoundly deaf" is preferable to the term "totally deaf." Therefore, as a suggestion, should this measure be favorably reported, the terminology used to describe the degree of hearing loss--"profoundly" versus "totally"--should be considered by the Committee.

Mr. Chairman, your introduction of this measure portrays the continued commitment that this Committee has to insure that the lives of these severely disabled and, in our opinion, heretofore sadly neglected veterans are improved to the maximum extent possible.

POST-TRAUMATIC STRESS DISORDER

The pressing need to enhance and expand the scope of the VA's involvement in the area of PTSD is addressed by the measures S. 2514 and S. Amendment No. 2850 to S. 2269.

Mr. Chairman, through its nationwide system of Outreach Centers and contract authority, the VA is now treating and providing medical services to a significant number of veterans suffering the effects of PTSD. Additionally, various VA medical centers have established inpatient PTSD "combat units" that offer intensive and specialized treatment for these veterans.

It is our understanding that these "combat units" function very well, albeit independent of each other, with an informal mechanism of sharing learned information.

The proposed measure, S. 2514, envisions to create a vehicle for the establishment of a formal, coordinated and centrally located PTSD mechanism, via the creation of an Associate Director for PTSD. The Associate Director would be responsible for developing policies, providing guidance, coordinating the provisions of services for Vietnam veterans with PTSD and conducting special education and training programs in this area.

Mr. Chairman, we feel the VA, in the various field stations and at Central Office, have the core ingredients to effectively administer and provide services to veterans suffering from PTSD. In our opinion, the creation of an Associate Director for PTSD will bring together the services being provided and form a closely knit and cohesive team effort of the program itself. Therefore, we would have no objection to the creation of such a position in VA Central Office.

REFERRALS OF VETERANS TO NON-VA ENTITIES AND ARRANGEMENTS FOR COMMUNITY SERVICES

S. 2514 proposes, by creation of a new Section--4120--in Title 38, United States Code, to designate one office in each VA health care facility and at VA Central Office to coordinate and make arrangements to assist veterans in obtaining health and health-related services from sources outside the VA, and at no expense to the agency, when such services are determined to be reasonably necessary in the effective treatment of veterans eligible for care under Chapter 17, Title 38, United States Code.

Additionally, the Administrator shall be required to place particular emphasis on the needs of service-connected disabled veterans rated 50% or more and veterans age 65 or older.

Mr. Chairman, a recent report by the VA detailing veterans' demands for medical care at VA facilities found that each month over 21,000 veterans (more than 250,000 veterans annually) seeking VA health care services are being turned away from the VA and thus not receiving the care they desperately need. It may be presumed that, with the estimated nine million veterans who will reach age 65 or older by 1990, the number of veterans seeking and being refused care will increase significantly.

In our opinion, the proposed intent of this measure is to create a mechanism whereby veterans requiring medical services who have no eligibility or whose eligibility to receive care falls at the lower end of the scale will be offered the maximum assistance possible to insure treatment is received from non-VA entities. (Some VA medical facilities now provide similar services, although smaller in scope, through established social work services.)

It is commendable, Mr. Chairman, that this Committee advances the desire to be of assistance to all veterans in need of medical services and proposes to establish a vehicle for doing so.

The DAV has no objection to the enactment of this legislation, with the following caveat:

The "particular emphasis" to be placed on the referral needs of service-connected veterans should be employed when, and only when, it is not advantageous or feasible to such veterans to receive care in a VA facility or at VA expense.

As you are well aware, Mr. Chairman, Section 612(f), Title 38, United States Code, states: "the Administrator, within the limits of Veterans Administration facilities, may furnish medical services for any disability on an outpatient or ambulatory basis...to any veteran who has a service-connected disability rated at 50% or more...."

As presently written, VA personnel at various medical facilities could misinterpret S. 2514 as a mandate to refer the service-connected disabled veteran to medical care sources outside of the VA system rather than furnish the needed medical services within the confines of VA health care facilities.

Referral of service-connected veterans must not be the norm, but the exception, and only after all other means of providing services have been explored, including the VA fee-basis program. We ask appropriate modification of the present language.

Finally, Mr. Chairman, we have not been mandated by our membership to pursue legislation regarding certain objectives contained in provisions of the various bills being considered today. Specifically, those provisions which address: amending the definition of the Vietnam Era; the authority to provide counseling services to family members or survivors of deceased veterans; extension of eligibility for readjustment counseling; VA protective services personnel; amending the time period for the Comptroller General to report to the Veterans Affairs Committees regarding medical personnel staffing levels; state home facility grant application approval; alternatives for federal government assistance to individuals who served in Vietnam as civilians; excluding payment for therapeutic and rehabilitation activities from annual income for purposes of nonservice-connected pension payments; contract care in Puerto Rico and the Virgin Islands; programs of the VA in providing hospice and respite care to certain veterans; and alcohol treatment and rehabilitation.

Although we have no official position on these measures, Mr. Chairman, we would not object to their enactment.

This concludes my statement, Mr. Chairman, I wish to again thank you and the members of the Committee for allowing us this opportunity to express our views on these important subjects.

Mr. **Principi**. Mr. Powell.

Mr. **Powell**. I was out of town yesterday, but the comments I got said to keep it to 5 minutes. It will not necessarily be on one subject, however.

First of all and perhaps most importantly, PVA strongly supports amendment No. 2850 to S. 2269, which would remove from accountability of income, income received from therapeutic or rehabilitative activity for the purposes of pension purposes. We believe this to be an effective, cost effective, humane, and a far-reaching proposition, which would substantially provide an opportunity to many young, non-service-connected veterans to attain rehabilitation or therapeutic training, which would allow them to become productive members of our society and get over that initial period with the problem of loss of income.

Second, PVA supports S. 2269. We believe, however, that it does not quite go far enough. We strongly believe that those veterans who served in Lebanon and Beirut and who watched their friends get killed and who had hostile fire pass by them suffered every bit of the anxiety, fear, and terror that was suffered by those of us who served in Vietnam or World War II and that they should, in fact, be entitled in total to the full range of readjustment benefits that have been provided to veterans of other conflicts. We consider this to be especially important, considering the fact that according to all of the wits on defense, this is the kind of situation that American military personnel will most probably face in the future. So we support S. 2269, but would like to see the provisions extended to provide full readjustment benefits for those who served in hostile fire areas.

Third, it certainly would not be appropriate if I did not comment on S. 2210, which is an ongoing saga of some 3 years of experience, and I know many of the staff members are certainly aware of that. First of all, PVA can understand no reason whatsoever for the retraction of an entitlement which has been appropriately, prudently, conservatively safeguarded by those beneficiaries who are eligible for that entitlement.

As a matter of fact, the Veterans' Administration claims that some 51,000 service-connected disabled veterans are eligible for the auto adaptive equipment program. In 7 years, from 1976 to 1983, those 51,000 veterans purchased and obtained approximately 56,000 vehicles, also from VA records.

I would like to point out that during that period of time under the present provisions, they were entitled to 450,000 automobiles. They, again, obtained only 56,000. It seems to me somewhat improper to retract eligibility for a benefit simply because it has not been utilized. In the VA's own analysis of what the benefits would be of reducing eligibility, the dollars. Out of a $25 billion area, it seems awful funny to be looking at the catastrophically disabled.

However, we can recognize that three automobiles in 2 years may be too many. We, therefore, strongly support the compromise recommendation proposed here today by Senator Cranston, proposing that the eligibility be two automobiles in a period of 3 years, also with a waiverability of ownership, so as to ensure that the disabled veteran is provided with backup transportation so he may continue the style of life the VA has rehabilitated him to lead.

With that, I am going to stop, because we have other comments that have already been submitted for the record.

Mr. PRINCIPI. Thank you.

[The prepared statement of R. Jack Powell, executive director, Paralyzed Veterans of America, follows:]

PARALYZED
VETERANS
OF
AMERICA
CHARTERED BY THE CONGRESS OF THE UNITED STATES

PREPARED STATEMENT OF R. JACK POWELL, EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. Chairman and Members of the Committee, it is a pleasure for Paralyzed Veterans of America to appear today and present the views and concerns of its members on the various legislative proposals being addressed. These proposals cover a wide range of health care issues, which affect our members and other veterans. I am R. Jack Powell, Executive Director of Paralyzed Veterans of America.

The first issue I must address is S. 2210, a legislative proposal to revise and clarify the eligibility of certain disabled veterans for automotive adaptive equipment by amending Title 38, United States Code, to restrict an eligible veteran to obtaining adaptive equipment for only one vehicle in a three-year period. PVA strongly opposes the passage of S. 2210 on the basis

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that it is unduly harsh and unrealistic if the purpose of the automobile adaptive equipment program is to be met.

The need for adaptive equipment for automobiles or other vehicles is essential if the most seriously disabled veterans are to achieve their basic transportation needs. Historically, this program has benefitted thousands of veterans and has assisted them in efforts to achieve maximum independence. The requirements for reliable day-to-day transportation has in no way diminished for seriously disabled veterans, and passage of S. 2210 will serve only to create an inflexible system whereby a veteran is not assured of having dependable transportation.

While the present program allows great flexibility in the number of vehicles a veteran can obtain, S. 2210 is extreme in the opposite direction by being overly restrictive. Recognizing that the proposal allows for some flexibility by providing the Administrator the authority to provide early vehicle replacement in exigent circumstances, it seems reasonable that a middle ground can be found to the satisfaction of all concerned.

PVA recommends that a veteran be eligible to obtain one vehicle in a two-year period and that the veteran be eligible to own two vehicles with VA-provided adaptive equipment at the same time. This proposal, while in some ways more restrictive than the present law, would insure the veteran of having dependable transportation with the additional safeguard of providing him a necessary back-up vehicle in the event that the primary vehicle is temporarily inoperable.

Mr. Chairman, we cannot over emphasize the importance of a dependable, properly equipped vehicle for catastrophically disabled veterans. In our automobile oriented society, reliable transportation is the key to independence. An automobile breakdown is an inconvenience for most citizens who then must rely on public mass transportation, the use of a second family vehicle, or the assistance of family members or friends for conveyance. For many catastrophically disabled veterans an automobile breakdown results in the veteran being stranded with no alternative means of transportation available. Public mass transit systems for the most part are inaccessible, under existing law no second family car is available for use, and vehicles of others are not equipped for operation and, in many cases, even preclude entry.

Our recommendation of one vehicle in a two-year period would go far in reaching the goal of a more tightly controlled program while still insuring the veteran a reasonable option for maintaining a reliable vehicle. Our second proposal would provide the veteran the opportunity to maintain a backup means of transportation. Realizing that the Veterans Administration has an investment in the installed equipment, we suggest that if the vehicle is less than three years old that the veteran have the option of maintaining the vehicle by purchasing the equipment at its depreciated value. If the vehicle is three years old or older, then the veteran should be able to keep the equipment at no charge, and, in either case, he would be afforded a necessary backup vehicle. Hopefully, Mr. Chairman and Members of the Committee, you will consider these proposals and recognize their merit in assuring catastrophically disabled veterans necessary, dependable transportation.

Mr. Chairman, I will now address several of the other proposals under consideration today. Rather than commenting on each individual proposal, section by section, I will only address those issues of specific concern to the members of PVA and that have the potential to affect the benefits and services upon which they rely.

Mr. Chairman, PVA strongly supports the proposal by Senator Alan Cranston, contained in Amendment Number 2850 to S. 2269, which would amend Section 618, Title 38, USC. The present situation of counting as income remuneration for therapeutic or rehabilitative activity for the purposes of pension payment is counter-productive and serves as a disincentive to younger catastrophically disabled non-service-connected veterans in attempting to rejoin the work force.

For several years, PVA has addressed the work disincentives in the NSC pension program and removal of payments for rehabilitative activities as counted income is a significant beginning in making this program a viable one for younger disabled pension recipients. To count as income educational or vocational training benefits, places an onerous burden on a pension recipient who is attempting to gain new skills necessary to regain employment. Far too often the catastrophically disabled NSC veteran is precluded form even making such an attempt due to the financial hardship created by the existing situation.

PVA views enactment of this provision as as cost-effective measure. Successful completion of a rehabilitative program, which results in employment, not only removes the veteran from the pension program but also places the veteran in the position of being a contributing, tax paying citizen. This effort coupled with the other recommendations made by PVA over the past several years regarding the removal of the other work disincentives in the NSC pension program will greatly enhance the viability of the program and will assist many younger, catastrophically disabled NSC veterans in returning to employment and more productive lives.

A second issue which we strongly support is the provision of S. 2514, which addresses respite care. Several federal programs and agencies currently have means for providing respite care and these efforts have proven extremely beneficial in obviating the need for in-patient care when a supportive spouse or significant other is temporarily unable to care for the ill or disabled individual. The proposal for the Administrator to report to Congress on respite and hospice care is a needed and overdue action which hopefully will lead to improved programs for chronically and terminally ill veterans.

For many catastrophically disabled veterans the role of family members is indispensable to their well-being. Frequently, due to no change in their own condition, they must rely upon expensive in-patient care when a supportive family member is temporarily unable to continue care provision. Hopefully, the report of the Administrator will also address the need for respite care to alleviate the psychological burdens placed on family members. Often the day-to-day care provided by a family member is overlooked even though it is essential in precluding a veteran's institutionalization. Periodic relief is needed for the supportive family member to provide for that individual's well-being, as well as, that of the chronically ill or disabled veteran.

Mr. Chairman, PVA commends your efforts and those of the ranking minority member, Senator Alan Cranston, in addressing the issue of post-traumatic stress disorder (PTSD). Your efforts to enhance the VA's ability to detect and treat PTSD are most welcome and necessary. For too long veterans of Vietnam have suffered the psychological impact of their experiences. These veterans have been faced with an unsympathetic society and a VA medical system which has had neither the resources nor experience to deal with their problems.

PVA, at this time, cannot determine which of the two proposals offers the greatest benefit to veterans who have experienced PTSD. The establishment of a task force and the creation of a national center both provide for improvements in the ability of the VA to detect and treat veterans who have experienced PTSD. Regardless of which proposal is adopted, or if an alternative, compromise approach is developed, it is hoped that the results of the effort can be quickly and efficiently transferred to local VA health-care facilities. It is incumbent upon Congress and the VA to act aggressively in this area. Too much time has already passed and the need for services to deal with PTSD are acute.

Closely related to the provisions relating to treatment of PTSD is the provision of S. 2269, which expands readjustment counseling and related mental health services to additional veterans. PVA supports this effort to extend these benefits to veterans who have served in hostilities subsequent to May 7, 1975. The impact of service under hostile fire is in no way mitigated by arbitrary dates. The results for the veterans who experience hostile fire is the same whether it be during a declared war, a police action or any other named circumstance.

Mr. Chairman, PVA supports this effort and we recommend that not only readjustment benefits be provided to veterans who have served in hostilities but the full range of wartime benefits. The veterans of Lebanon and Grenada served honorably, were wounded and killed. Those who survived there and in other hostile actions are deserving of the full range of VA services and benefits which veterans of wartime service already receive.

The proposal contained in S. 2269 to extend counseling services to certain survivors of deceased veterans is a most worthwhile effort. PVA supports such services because the needs and well-being of family members are inextricably tied to the services and sacrifices of individual veterans. This is particularly true in the case of catastrophically disabled veterans where family members have spent years caring for and supporting the veteran. The veteran's death is a traumatic time for the family and support services and counseling are critical elements in assisting family members in their readjustment.

Mr. Chairman, PVA is pleased to note that the legislative proposals, S. 2514, S.2269, and S. 2278, all seek to continue, and make permanent, the VA's program for treatment and rehabilitation for alcohol or drug dependence or abuse. These efforts reflect the realization that many veterans continue to suffer these disabling conditions and that, frequently, many of these veterans can be rehabilitated and regain fully productive lives. The success of the VA's efforts are positive, and the continuation of these programs offers hope and support for veterans.

PVA endorses the concept of half-way houses and residential treatment centers in the treatment and rehabilitation for alcohol and drug dependence. Support from fellow veterans in non-institutional settings have proven to be positive sources of successful rehabilitative endeavors. We oppose, however, Section 3 (1) (c) of S. 2514, which would establish a maximum period of 60 days for one episode of treatment. PVA believes the period of treatment is a medical determination and should not be restricted by statute. The period of treatment should be addressed on a case-by-case basis with consideration being based on the individual veteran's potential for successful rehabilitation.

Finally, Mr. Chairman, PVA must comment on the proposal to add Section 4120 to Chapter 73, Title 38 USC. We are concerned that, as proposed, the referral service is designed to direct veterans away from the VA health-care system rather than into it for treatment and services. This is of particular concern to PVA's members who are reliant on the specialized care provided by the VA's Spinal Cord Injury service.

PVA recognizes that when VA services and facilities are not available for specific medical conditions referral services could prove to be of considerable value to the individual veteran. However, a referral service designed to direct veterans to health-care services outside the VA system and at no cost to the VA can only serve to diminish and dilute the efficacy and availability of VA health care. The VA is the primary health-care provider for eligible veterans, and such an effort could serve to undermine the system.

Over the years the VA has proved to be a cost-effective health-care provider. To direct veterans away from this system and into more costly health-care delivery systems, which would be paid for by other federal programs, private insurers or by the veteran himself would result in reduced health care for the veteran and increased health care costs. Additionally, such a referral service while designed as a management initiative to enhance care and treatment programs would ultimately be a management initiative to oversee the dissolution and dismantling of the health-care system by eroding the patient base.

Mr. Chairman, Paralyzed Veterans of America is grateful for the efforts that have gone into conducting this hearing today. We appreciate the concern for the nation's veterans which is held by you, by Members of the Committee, by other Members of the Senate, and by this Committee's capable and cooperative staff. This concern has been revealed here, today, by the willingness to address and examine these various legislative proposals, which, if enacted, would affect health-care programs for veterans, their survivors and dependents.

Mr. Chairman and Members of the Committee, on behalf of the members of PVA, I appreciate your invitation to present our views and recommendations and your attentiveness to the concerns which I have expressed during this presentation. This concludes my statement, and I will be glad to answer any questions that I can.

Mr. Principi. Mr. Powell, the VA opposes a provision in S. 2514 which would provide TV telecaptioning decoders to totally deaf veterans on the grounds that it is not a rehabilitative device. If the purpose of prosthetic and sensory aids is to provide a direct form of assistance to overcome a specific handicap, how is a TV decoder which would provide a communication device for a deaf veteran with a communication handicap, different than an automatic page turner for a paralyzed veteran with a mobility handicap?

Mr. Powell. In trying to understand the rationale behind the VA's opposition to the provision of a decaptioning or encaptioning device, I was unable to find where they got that decision from. And quite honestly, their argument escapes me. We certainly believe it is a very appropriate device to be provided to those that have hearing loss.

Mr. Principi. Thank you. S. 2269 proposes to expand eligibility for VA readjustment counseling to certain active duty military personnel within the limits of VA facilities. This raises two kinds of questions which I would ask each of you to address.

First, where is the division of responsibility between the VA and DOD? Should the VA in the absence of a sharing agreement with DOD treat active duty personnel in this manner?

Mr. Sommer. Mr. Chief Counsel—John Sommer of The American Legion—I believe that was covered earlier in an exchange between Senator Cranston and Dr. Custis. As far as The American Legion is concerned, it would depend upon whether or not the identity of the individual on active duty that was receiving counseling from the VA was provided to DOD. That would make a difference as to whether or not we could support such a provision. We raised the concern in our statement that many individuals that are on active duty now that served in Vietnam are career-oriented individuals; they are senior enlisted personnel and officers, who would not submit to a DOD counseling program because of the problem in getting a psychiatric diagnosis included in their service medical records which could jeopardize future advancements within the military.

Therefore, our support would depend a great deal on whether or not the identities of the individuals who were receiving counseling would be given to DOD as a condition of reimbursement.

Mr. Gorman. David Gorman, DAV. I think our bottom line consideration would be that as long as that counseling would not interfere with the counseling of otherwise entitled service-connected veterans, that would be our main concern in that area.

Mr. Mayo. Phil Mayo, VFW. We indicated in our testimony that it should be as a reimbursable admission. Our consideration did not include the possibility of recriminations of some sort to service members. And rather than respond to that at this time, I would prefer to go back and discuss it with our staff to see how our technicians, would react to that.

Mr. Powell. Jack Powell, PVA. I am somewhat concerned that PTSD treatment to veterans postservice and PTSD treatment to veterans remaining on active duty share the same similarities as oaks and acorns. The problem may end up being the same, but there are substantially different variations to it. Part of the treatment for PTSD involves some of the withdrawal of the friendship and comradery that the individual veteran shares in as part of his active duty in the military. That has not changed for those who are on active duty.

There is some question about it—certainly going on in Dr. Custis's remarks. Looking at the resources that the Department of Defense has provided to it for health care, I cannot believe that the Department of Defense lacks the financial resources or should lack the medical resources to be able to provide appropriate PTSD counseling for active duty military personnel.

Mr. **Mayo**. I would add that part of the impetus in our taking the position that we did was to create an inducement among the military community, active military community to become more interested in this phenomenon.

Mr. **Principi**. I will forgo the next part of the question and submit it for the record in the interest of time. Thank you very much. I appreciate your being here. And, again, I regret the absence of the chairman.

[The responses of The American Legion, Veterans of Foreign Wars of the United States, Disabled American Veterans, and Paralyzed Veterans of America, to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, and Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follow:]

RESPONSE OF THE AMERICAN LEGION TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. With regard to the alcohol treatment provision in your written testimony you said, "We do believe that some controls on recidivism need to be defined and established, whether by statute, which would be difficult, or by treatment guides developed by Central Office." How would such controls be reconciled with legislated eligibility for services?

Answer 1.

In your first question we are asked how, with regard to alcohol treatment, recidivism controls would be reconciled with legislated eligibility for services. The answer to this question is best seen in light of the proposition that eligibility does not necessarily have to constitute a guarantee that treatment will be rendered. If it is desirable to establish continuity in VA's alcohol treatment programs by asking VA to establish treatment guidelines, and we think that it is, at least part of those guidelines should address the problem of recidivism seriously.

The American Legion has no interest in seeing veterans move in and out of VA alcohol treatment in revolving door fashion. Many who either do or would, are veterans lacking in motivation for rehabilitation and who use the VA as a refuge. We disapprove of this prospect and believe a veteran serious about alcohol rehabilitation be required to establish both his seriousness and eligibility by agreeing to submit to the entire program, regardless of the number of stages prescribed by VA guidelines and regardless of program length.

Question 2. Sometimes around this place, we are faced with ideas and situations which have enormous emotional appeal. Yet, in this time of limited resources faced with enormous deficits, we need to take a hard look at what we are doing, what we want to do, and then, what we would like to do, but must postpone or deny. One of these appealing ideas is contained in a provision of S. 2269 which would authorize the VA to provide bereavement counseling services to family members of a deceased veteran if the family members were recipients of counseling services at the time of the veteran's death. The nature of counseling services provided to assist family members with emotional and psychological stress of death is quite different from counseling services provided before the veteran's death. Thus, the bereavement counseling provision in S. 2269 might be seen as a new service, no matter how meritorious its benefits, rather than as a eligibility question. What do you think about this distinction?

Answer 2.

The next question concerns bereavement counseling, as provided for spouses of deceased veterans in S. 2269. Might this come to be viewed as yet another service offered by VA rather than as an eligibility extension? We have to believe, Mr. Chairman, that such spouses who would seek counseling at Vet Centers would be few in number because eligibility would be limited to only those spouses who had already been getting assistance at the Vet Center prior to the veterans death.

Under the circumstances, it seems likely that such spouses would have emotional problems directly related to the veteran's psychological readjustment problems. Assuming this to be the case, the nature of the counseling rendered by the Vet Center would encompass more than just bereavement counseling per se.

In that regard, it is difficult to imagine a clinical circumstance in which a Vet Center counselor could distinguish that counseling given for bereavement and that given for some other psychological problem. This is because in treating psychologically afflicted individuals, it is a practical impossibility to treat individual problems separately regardless of the modality employed.

Question 3. S. 2269 proposes to expand eligibility for VA readjustment counseling to certain active duty military personnel within the limits of VA facilities. This raises for me two kinds of questions which I would ask each of you to address.

A. First, where is the division of responsibility between the VA and DOD? Should the VA, in the absence of a sharing agreement with DOD, treat active duty personnel in this manner?

B. Second, what is the meaning of the words "within the limits of Veterans' Administration facilities". The idea of making use of all of the capacity of the VA is good, but we all see problems of how to implement priority eligibilities at medical centers. Do we want to create the same problems in a program we already know is in high demand from veterans?

Answer 3.

Another of the questions concerns extension of Vet Center eligibility to active duty military personnel who might be encountering psychological difficulties as a result of service in Vietnam or some other trouble spot in which U.S. combat troops were engaged in hostilities. As with bereavement counseling, the numbers of active duty personnel availing themselves of Vet Center counseling would be small. The most obvious reason for this is the limited availability of Vet Centers geographically situated near military bases.

Another, perhaps more compelling reason for the limited use of Vet Centers by active duty personnel stems from what is now known about Post Traumatic Stress and other combat related psychological readjustment problems. For example, the Vietnam experience in which veterans were denied sufficient time to decompress and ventilate anxieties between the time they were moved out of combat and returned to the United States has been shown to constitute a psychological shock. Also, Vietnam veterans were rotated in and out of the war individually rather than in unit groups.

This marked a significant departure from the experience of World War II in which unified groups of combatants were placed on troop ships and slowly returned with their buddies to more peaceful settings in either Europe or the United States. Moreover, knowledge of the value of decompression and ventilation over time with one's combat peers has served to explain much of the psychological phenomenon of the Vietnam veteran.

Perhaps ironically, the incidence of this psychological phenomenon can be expected to be much less in the case of the Vietnam soldier having opted to make a career of military service. This is because for many of these individuals, the decompression or ventilation denied the soldier having left service and become a veteran has been provided to the careerist whose peers have shared the same experiences in Vietnam. The close proximity of many such peers on the military base has to be seen as having afforded careerists an informal opportunity to either prevent or significantly reduce the potential for developing psychological problems secondary to combat in Vietnam or elsewhere.

Another facet of this question concerns the propriety of VA provisions of services to DoD personnel in the absence of a sharing agreement. As we pointed out in our written statement, active duty personnel desiring counseling for combat related psychological problems probably would avoid requesting counseling from DoD for fear of career advancement reprisals steming from the stigma attached to this type of treatment. For these individuals, confidentiality is critically important and could not be assured if treatment were offered by Vet Centers through a formal sharing arrangement.

Question 4. Last year we talked about moving the beginning date for the Vietnam Era from its current date of August 5, 1964, to July 8, 1959. Each of you spoke in a way that reflected your appreciation of the several considerations of such a move. So, I would ask each of you again, what impact would the change in definition of the Vietnam Era have on Vietnam veterans and how do your members now view the proposed change?

Answer 4.

The final question asks for clarification of our views on redefining the Vietnam Era. The redefinition provided in S. 2269 would change the current beginning date of the Vietnam Era from August 5, 1964 to July 8, 1959. Our position, on redefinition is unchanged from last year. The American Legion simply has no existing authority in the form of a resolution from our membership to either support or oppose a change.

RESPONSE OF THE AMERICAN LEGION TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1A. On page 3 of your statement, you note your support for the issuance by the Central Office of "treatment guides" relating to alcohol and drug treatment programs. Would your support for such guidance extend to the issuance, as would be required by section 3 of S. 2514, of regulations which "establish maximum periods of treatment" for alcohol or drug dependence or abuse disabilities, including "specific maximum periods" for specified treatment steps?

B. (i) (If yes) Do you also support such maximum periods being "consistent with average periods" of treatment for such conditions by non-VA programs?

(ii) (If yes) Would not this preclude longer-than-the-minimum-period stays that are common in the community and which along with shorter-than-usual-period stays contribute to the community "average period"?

C. Would you also support, as is proposed in section 3 of S. 2514, establishing by statute a maximum period (60 days) for an episode of treatment in a halfway house?

Answer 1A. As the statement indicates the Legion believes the overall VA treatment programs for these conditions have now been in place for a sufficient length of time so that Central Office should coordinate the programming in the VAMCs to use those modalities that have proven most effective and eliminate those that are less so. We make this statement because it is our perception there is not very much Central Office coordination presently in this field. Most treatment units seem to be developing programs based on the ideas of the responsible medical officer, and these ideas vary widely.

We do not believe legislation can mandate the length of treatment programs. Central Office can and, in our judgment should set treatment guidelines. But even then, some flexibility should be left in the guidelines to accommodate the perceived needs of individual cases.

Similarly, we do not believe the length of needed detoxification can be mandated. That is entirely a matter of medical judgment to be applied in individual cases. We do believe there should be provision for detoxification preparatory to rehabilitation - when possible on the Treatment Unit. Some VAMCs do the detoxing on the medical service, and some VAMCs will not admit for detoxing absent a medical emergency.

To repeat, we do see the need for Central Office guidelines for treatment lengths. Some Units maintain programs that are too long. In the private sector most rehabilitation programs are 28 days in length - and in most cases this is sufficient.

The other problem is recidivism, which, in some programs is far too prevalent. Some alcoholics, lacking in motivation for rehabilitation will use VA as a refuge, and we disapprove of this because that is not the purpose of the VA's alcohol and drug abuse treatment programs.

Answer 1B(i). We would prefer to see the Congress not get into any legislation mandating treatment lengths. We believe Central Office has ample authority to set treatment guidelines.

Answer 1B(ii). As above.

Answer 1C. Here again, we do not believe it advisable to legislatively mandate length of treatment in Halfway Houses, although there certainly must be limits put on that element of a rehabilitation program. We do not see why Central Office cannot manage this aspect through guidelines. We will say that if the oversight Committees became aware that veteran patients were being maintained in Halfway Houses for inordinate lengths of time, contrary to established guidelines, corrective legislation might come to be seen as necessary. The objective is to prevent any element of a rehabilitation program from being used as a refuge by persons not motivated to rehabilitation, or by those who tend to become institutionalized.

Question 2. On pages 2 and 15, you discuss provisions in S. 2514 and S. 2269 relating to the pilot program under section 620A of title 38 as though that pilot program related to the VA's entire overall program for the treatment and rehabilitation for alcohol or drug dependence or abuse disabilities.

Question 2A. Do you agree that section 620A relates only to the VA's authority to contract with halfway houses and other community-based facilities and that even if it were not extended--and I fully expect that it will be--the VA would still have authority to provide a full range of in-house care and treatment to veterans suffering from such disabilities?

Question 2B. With this clarification, do you support making the pilot halfway-house authority permanent?

Answer 2A. Yes, we do agree.

Answer 2B. As we indicated, we hope clearly, in our statement of April 11, 1984, The American Legion believes it is appropriate at this time to eliminate the reference in statute and in the title, to programs for alcohol and drug abuse disabilities as "pilot programs." These programs, and the need for them is clear for all to see. The VA is doing good work in this field and much more needs to be done.

RESPONSE OF THE VETERANS OF FOREIGN WARS OF THE UNITED STATES TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. As you know, Public Law 95-202 provides for an administrative determination respecting whether the service of any non-military group of individuals was equivalent to, or tantamount to, active military service. This law has been implemented by the Department of Defense as the Defense/Civilian Review Board. A finding that service was tantamount to military service confers veteran status. What is the view of your members regarding the defense civilian military review board and what is your view toward providing federal benefits for those whose service is not deemed to be tantamount to military service?

Answer 1. We have no objection to "Federal Benefits" being conferred upon those federal civilian employees whose service is not deemed to be tantamount to military service. We believe such benefits may be paid for and provided by the agency in question; we would not support the application of VA resources to such an end. "Federal Benefits" currently are available to those employed in the public and private sector who experience work related injuries and illness.

Our view with respect to the Defense/Civilian Review Board is that such, under the auspices of the Secretary of Defense, constitutes the proper forum for making decisions with respect to whether or not service is tantamount to military service.

Question 2. S.2269 proposes to expand eligibility for VA readjustment counseling to certain active military personnel within the limits of VA facilities. This raises for me two kinds of questions which I would ask each of you to address.

A. First, where is the division of responsibility between the VA and DOD? Should the VA, in the absence of a sharing agreement with DOD, treat active duty personnel in this manner?

B. Second, what is the meaning of the words "within the limits of Veteran's Administration facilities." The idea of making use of all of the capacity of the VA is good, but we all see problems of how to implement priority eligibilities at medical centers. Do we want to create the same problems in a program we already know is in high demand from veterans?

Answer 2A. It should be noted that the VA is the primary backup to the DOD insofar as hospital care for those injured in the line of duty. Needed counseling services may be provided active duty personnel who require such, first, in the military community. If such is not available, then we believe those services may be provided as indicated in our testimony on page 4 by the VA.

Answer 2B. We do not perceive there will be an overwhelming demand, by huge numbers of active duty personnel, on Vet Centers. We believe providing counseling to those individuals would be minimal in nature.

Question 3. Sometimes around this place, we are faced with ideas and situations which have enormous emotional appeal. Yet, in this time of limited resources faced with enormous deficits, we need to take a hard look at what we are doing, what we want to do, and then, what we would like to do, but must postpone or deny. One of these appealing ideas is contained in a provision of S.2269 which would authorize the VA to provide bereavement counseling services to family members of a deceased veteran if the family members were recipients of counseling services at the time of the veteran's death. The nature of counseling services provided to assist family members with emotional and psychological stress of death is quite different from counseling services provided before the veteran's death. Thus, the bereavement counseling provision in S.2269 might be seen as a new service, no matter how meritorious its benefits, rather than as an eligibility question. What do you think about this distinction?

Answer 3. We do not concur in the assumption upon which the question is based: that is, a substantial difference exists between, in the case of family readjustment counseling, the services being provided before and after a veteran's death.

The death of a veteran, who along with family, is undergoing readjustment counseling does not change the fact that a process, involving the family unit, was going on at the time of the veteran's death. Counseling, in our view should continue and not be stopped—it should "wind down" during the bereavement period. The death of the veteran constitutes an event during the process of treatment—not the conclusion of it. We believe that the cessation of counseling after the death of the veteran is analogous to termination of post operative follow-up treatment after major surgery. The death of the veteran does not obviate the need to bring the process of counseling to an orderly conclusion.

Question 4. Last year we talked about moving the beginning date for the Vietnam era from its current date of August 5, 1964, to July 8, 1959. Each of you spoke in a way that reflected your appreciation of the several considerations of such a move. So, I would ask each of you again, what impact would the change in definition of the Vietnam era have on Vietnam veterans and how do your members now view the proposed change?

Answer 4. Our views are reflective of current criteria for membership in the VFW; therefore, we refer you to page 4 of our testimony. Vietnam veterans contacted in connection with your question indicated they did not believe this change would have any impact on them, but should have a positive impact on those affected.

RESPONSE OF THE VETERANS OF FOREIGN WARS OF THE UNITED STATES TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. With reference to your views, set forth on page 7 of your statement, regarding the priority for the establishment of a national PTSD center within the VA, would your view be different if the VA, instead of establishing a new facility, provided additional resources to one of the PTSD inpatient units already in existence so as to convert that unit into a center for excellence that could assume a leadership role within the VA on the diagnosis and treatment of the disorder and in disseminating PTSD information and learning throughout the system?

Answer 1. We do not believe additional resources provided to one of the PTSD units would be inconsistent with our views. We recognize, that when a more formal structure is developed and implemented [for this program] that such a center may be an integral part thereof.

Again, however, we emphasize our views as to the commitment of human and physical resources to this undertaking. The commitment of these resources, we believe, would aid immeasurably in accomplishing the purposes of a center as envisioned in S.2269.

Question 2. With respect to automobile adaptive equipment, after reviewing the VA's testimony on S.2210 and that of all the veterans organizations, I think compromise result might well be to permit an eligible veteran to receive two VA equipment adaptations in any three-year period as part of which the veteran would also be permitted to maintain a second VA-adapted vehicle for backup purposes. Please comment on this approach as an alternative to the approach in S.2210 limiting asistance to one in three years. It seems preferrable to me to permit more latitude in terms of acquiring a backup vehicle and also more latitude as to a replacement vehicle without establishing a cumbersome administrative mechanism to determine how exceptions are merited.

Answer 2. Upon further review, and extensive consultation with those who have firsthand knowledge of adaptive equipment needs, we believe the approach you suggest to be a reasonable one. We do not believe abuse will result in this particular program because of administrative checks and balances, as well as the fact that the high cost of automobiles/conveyances serves to limit its use. We definitely support the authorization of the veteran being able to own more than one adaptive vehicle and reasonable flexibility in the program.

RESPONSE OF THE DISABLED AMERICAN VETERANS TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. Bereavement counseling provision in S. 2269.

Sometimes around this place, we are faced with ideas and situations which have enormous emotional appeal. Yet, in this time of limited resources faced with enormous deficits, we need to take a hard look at what we are doing, what we want to do, and then, what we would like to do, but must postpone or deny. One of these appealing ideas is contained in a provision of S. 2269 which would authorize the VA to provide bereavement counseling services to family members of a deceased veteran if the family members were recipients of counseling services at the time of the veteran's death. The nature of counseling services provided to assist family members with emotional and psychological stress of death is quite different from counseling services provided before the veteran's death. Thus, the bereavement counseling provision in S. 2269 might be seen as a new service, no matter how meritorious its benefits, rather than as an eligibility question. What do you think about this distinction?

Answer 1.

While it may be true that the nature of counseling services provided to family members prior to a veteran's death differs in scope and focus from those provided after death, they may also be viewed as a necessary continuation of services. Bereavement counseling may be described as an integral portion of the total care to be provided to the terminally ill veteran. This is so due to the nature of the treatment employed in preparing the veteran and family for death from a physical, social, spiritual and emotional standpoint. Therefore, the distinction of bereavement counseling being a new service to be provided versus an eligibility question is difficult to determine.

Question 2. Expanded eligibility for readjustment counseling.

S. 2269 proposes to expand eligibility for VA readjustment counseling to certain active duty military personnel within the limits of VA facilities. This raises for me two kinds of questions which I would ask each of you to address.

A. First, where is the division of responsibility between the VA and DOD? Should the VA, in the absence of a sharing agreement with DOD, treat active duty personnel in this manner?

B. Second, what is the meaning of the words "within the limits of Veterans Administration facilities." The idea of making use of all of the capacity of the VA is good, but we all see problems of how to implement priority eligibilities at medical centers. Do we want to create the same problems in a program we already know is in high demand from veterans?

Answer 2.

A. The division of responsibility between the Veterans Administration and the Department of Defense in providing medical care and services, in the absence of a sharing agreement, is implied by the overall responsibilities and mandates of the agencies involved. That is, the medical care needs of veterans must be met by the VA and the medical care needs of active duty personnel must be met by DOD. Retired military personnel who may also be eligible for medical care under the auspices of the VA should have the freedom and latitude to chose where they receive medical care. If the intent of readjustment counseling--which we believe it is--is to assist veterans in readjusting to civilian life, then we see no need nor constructive purpose to extending such services to active duty personnel. If a need exists for active duty personnel to receive this type of counseling service, it is certainly feasible for DOD and within their realm of responsibility to establish the capabilities to provide such.

B. The meaning of the phrase "within the limits of Veterans Administration facilities" may receive different connotations from different people. A workable meaning ascribed to the phrase, in context of providing medical, care may be to deliver quality and total medical care and services to eligible veterans to the fullest extent possible within the bounds of the VA's capabilities and budgetary restraints. The VA's ability to provide such services to service-connected disabled veterans must not be compromised or diminished in any fashion.

Question 3. Redefining the Vietnam Era.

Last year we talked about moving the beginning date for the Vietnam Era from its current date of August 5, 1964, to July 8, 1959. Each of you spoke in a way that reflected your appreciation of the several considerations of such a move. So, I would ask each of you again, what impact would the change in definition of the Vietnam Era have on Vietnam veterans and how do your members now view the proposed change.

Answer 3.

The redefinition of the beginning date of the Vietnam Era, as proposed by Section 2 of S. 2269, "...in the case of a veteran who served in the Republic of South Vietnam during the period beginning on July 8, 1959 and ending on May 7, 1975..." was addressed by the DAV in hearings before the Senate Committee on Veterans Affairs on March 10, 1983. Then, as now, we have no official position on this provision. However, enactment of this measure would have no impact on Vietnam veterans nor would there be any additional benefits that would accrue to service-connected veterans from this legislation. Additionally, it remains our feeling that, if enacted, all veterans who served from the date specified should be accorded the same status and type of benefits.

Question 4. Prosthetics.

The VA opposes a provision in S. 2514 which would provide TV telecaptioning decoders to totally deaf veterans on the grounds that it is not a rehabilitative device. If the purpose of prosthetic and sensory aids is to provide a direct form of assistance to overcome a specific handicap, how is a TV decoder, which would provide a communication device for a veteran with a communication handicap, different than a wheelchair for a veteran with a mobility handicap?

Answer 4.

Aside from physical characteristics and distinct functional purposes, there is not, in our opinion, a significant degree of difference. The profoundly deaf veteran is totally precluded from all forms of everyday communication. A mobility impaired veteran may be precluded from ambulation without resort to a wheelchair, which acts as a substitute for a weakened, deformed or missing lower extremity(ies). Depending on the nature and degree of disability, mobility is hindered without a wheelchair, however, it is possible that other compensatory devices or aids may be utilized, i.e., walkers, crutches, canes, braces, etc. For the profoundly deaf, the single device available that would permit a veteran to achieve a higher level of rehabilitation or realize a direct and defined therapeutic value is a television telecaptioning decoder. As a wheelchair compensates for a mobility handicap, a television telecaptioning decoder compensates for deficiencies of a sensory organ--the ears--and acts as a substitute for that non-functioning organ.

Question 5. Federal assistance to civilians who served in Vietnam.

As you know, Public Law 95-202 provides for an administrative determination respecting whether the service of any non-military group of individuals was equivalent to, or tantamount to, active military service. This law has been implemented by the Department of Defense as the Defense/Civilian Review Board. A finding that service was tantamount to military service confers veteran status. What is the view of your members regarding the Defense/Civilian Military Review Board and what is your view toward providing federal benefits for those whose service is not deemed to be tantamount to military service?

Answer 5.

The Department of Defense/Civilian Military Review Board appears to serve as an appropriate mechanism to determine if civilian employment or contractual service rendered by groups to the Armed Forces may be considered active military service, for the purposes of all laws administered by the Veterans Administration. Providing any type of federal benefits to individuals who did not derive such entitlement or eligibility from the performance of active military service is not a responsibility vested in the Veterans Administration. We could not support the expenditure of VA funds for such a purpose nor for the purpose of determining what, if any, type of federal assistance may be provided to individuals who are not veterans of the Vietnam Era. If VA guidance or input is deemed vital and mandatory to the resolution of such a question, then it should be accomplished at no expense to the agency.

RESPONSE OF THE DISABLED AMERICAN VETERANS TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1.

I would appreciate it if you would provide for the record more detail on your organization's views on the various legislative issues mentioned on page 9 of your statement as to which you indicated no opposition to their enactment.

Answer 1.

The redefinition of the beginning date of the Vietnam Era, as proposed by Section 2 of S. 2269, "...in the case of a veteran who served in the Republic of South Vietnam during the period beginning on July 8, 1959 and ending on May 7, 1975..." was addressed by the DAV in hearings held before the Senate Committee on Veterans Affairs on March 10, 1983. Then, as now, we have no official position on this provision. However, enactment of this measure would have no impact on Vietnam veterans nor would there be any additional benefits that would accrue to service-connected veterans from this legislation. Additionally, it remains our feeling that, if enacted, all veterans who served from the date specified should be accorded the same status and type of benefits as are currently provided to veterans who served during other wartime periods.

Section 3 of S. 2269 would permit the VA to continue to provide counseling services to family members at the time of the death of a veteran for a period not to exceed six months. Bereavement counseling may be described as an integral portion of the total care to be provided to the terminally ill veteran. This is so due to the nature of the treatment employed in preparing the veteran and family for death from a physical, social, spiritual and emotional standpoint. Therefore, we have no objection to the enactment of this measure so long as funding for that portion of the program expended for nonservice-connected veterans does not adversely impact upon the programs and services that would otherwise be provided to service-connected veterans.

Section 4 of S. 2269 would, in essence, expand eligibility for certain veterans to receive readjustment counseling, as well as establish eligibility for active duty personnel to receive such counseling. The DAV has no objection to expanding eligibility for readjustment counseling to those veterans who served on active duty after May 7, 1975 and were subjected to danger from armed conflict comparable to the danger experienced by military personnel in battle with the enemy during a period of war. However, we do not favor extending these types of counseling services to active duty personnel. If a need exists for active duty personnel to receive readjustment counseling services, it is certainly feasible and within the realm and responsibility of DOD to establish these types of services.

We favor Section 5 of S. 2269 which would make permanent the VA's authority for furnishing care in the treatment and rehabilitation for alcohol, drug dependence or abuse disabilities in community based treatment facilities. Although the intent is understood, we question the provision of Section 3 of S. 2514 that would statutorily dictate the medical management of dependence or abuse disabilities. Treatment of these cases is best left to the judgement of the medical profession and should not be prescribed in regulatory or in statutory form.

Both S. 2269 and Amendment No. 2850 to that measure contain provisions to clarify and improve the function of the VA protective services personnel. We would make two suggestions regarding this measure as currently constructed. First, should this measure be favorably reported, language specifically requiring that all VA police officers receive specialized training and instruction in the management and handling of veterans in a hospital environment, especially with respect to the emotionally disturbed veteran, should be included. Second, as it is the policy of the United States to promote maximum employment and job advancement opportunities within the federal government for qualified disabled veterans and veterans of the Vietnam Era, we suggest that this policy be made a part of any accompanying report language to this measure.

Section 7 of S. 2269 would clarify the time frame for submission of the Comptroller General's Report required by Section 5010, Title 38, United States Code. Although the DAV has no official position on this measure, it appears to place an additional degree of accountability upon the Office of Management and Budget and, therefore, we would favor its enactment.

Section 8 of S. 2269 would, if enacted, require that the Administrator of the VA assign a priority to each application received from a state seeking a grant for construction, expansion, remodeling or altering existing buildings of state home facilities for furnishing domiciliary or nursing home care to veterans, if funds appropriated for any fiscal year are not sufficient to make all the grants requested of the VA for that fiscal year. Although we have no official position on this measure, we find no compelling circumstances that would prompt us to support a major change in an established and apparently effective program that has otherwise funded projects in an equitable fashion.

Section 9 of S. 2269 would require the joint effort of the Veterans Administration, the Secretary of Defense and the Secretary of Health and Human Services to report to the Congress on alternatives for federal government assistance to individuals who served in Vietnam as civilians. Public Law 95-202 created the Department of Defense/Civilian Military Review Board whose function is to determine if civilian employment or contractual service rendered by groups to the Armed Services may be considered active military service for the purposes of laws administered by the Veterans Administration. We feel this Board serves as an appropriate mechanism to resolve such questions. Providing any type of federal benefits to individuals who did not derive such entitlement or eligibility from the performance of active military service is not a responsibility of the Veterans Administration. Additionally, we could not support the expenditure of VA funds for such a purpose, nor for the purpose of determining what, if any, type of federal assistance may be provided by such individuals who are not veterans. If it is felt that VA guidance and input is deemed vital and mandatory to the resolution of such a question, then it should be accomplished at no expense to the agency.

In order that veterans residing in Puerto Rico and the Virgin Islands may continue to receive medical care, on a contract basis, the extension, to September 30, 1984, as contained in Section 10 of S. 2269, seems necessary. While we have no objections to this measure, the VA should be reminded to develop, on an expeditious basis, feasible alternatives to provide such care.

DAV support of Section 11 of S. 2269 would be predicated on a similar concession offered to service-connected veterans in receipt of a total disability evaluation based on individual unemployability. With the primary emphasis on these programs being the therapeutic value derived, then the service-connected veteran should not be subjected to a possible loss of entitlement to individual unemployability based upon participation in these activities being perceived as gainful employment.

Section 6 of S. 2514 would require the Administration, not later than September 30, 1985, to submit a report to the House and Senate Committees on Veterans Affairs on the VA's programs for terminally ill and certain other veterans. Due to the importance of these type of medical care programs and, in consideration of the aging veteran situation and the DAV's desire to monitor the VA's efforts in these directions, we would concur in the compilation of such a report.

Question 2.

With respect to automobile adaptive equipment, after reviewing the VA's testimony on S. 2210 and that of all the veterans' organizations, I think a compromise result might well be to permit an eligible veteran to receive two VA equipment adaptations in any three year period as part of which the veteran would also be permitted to maintain a second VA adapted vehicle for backup purposes. Please comment on this approach as an alternative to the approach in S. 2210 limiting assistance to on in three years (subject to case-by-case exceptions) and thus permitting a backup vehicle only after the veteran has had the adapted vehicle for three years. It seems preferable to me to permit more latitude in terms of acquiring a backup vehicle and also more latitude as to a replacement vehicle without establishing a cumbersome administrative mechanism to determine how exceptions are merited.

Answer 2.

As indicated in DAV testimony of April 11, 1984, we have been mandated by the delegates to our most recent National Convention to seek the enactment of legislation that would permit VA reimbursement of automobile adaptive equipment without regard to the disposition of a previously adapted automobile for which reimbursement has been received. S. 2210 satisfies this mandate by appropriate amendment to Section 1903(c), Title 38, United States Code. The VA has testified that the average utilization of the adaptive equipment program for the last three fiscal years has been approximately one vehicle each 6.4 years. Current VA policy permits an eligible veteran to acquire and gain reimbursement for adaptive equipment on up to three vehicles in a two year period. The VA offers no objection to the removal of the bar of transferability of a previously adapted vehicle, as contained in S. 2210 and strongly recommends a one vehicle in two year restriction. In their written testimony, the Paralyzed Veterans of America apparently agrees with the one vehicle in two year provision. The American Legion and VFW concur in S. 2210 as constructed. Current law contains no statutory limitations on how frequently eligible veterans may purchase a new vehicle and obtain reimbursement for adaptive equipment. The DAV's concern in the adaptive equipment program has always surrounded the issue of disposal/transferability of the previously adapted vehicle and not necessarily the limitation on the number of vehicles that may be acquired and the veteran's entitlement for reimbursement. The VA's estimate of the frequency of utilization rate does not indicate that the one in three year limitation is overly restrictive. They do recognize, however. that a one in two year limitation may be desirable based on the need for severely disabled veterans to possess extremely dependable transportation. The PVA apparently concurs in this assessment in written testimony presented to the Committee, but favored the Cranston compromise in oral remarks.

The DAV continues to strongly support the intent of S. 2210 regarding the issue of disposal/transferability. However, the authority for the veteran to retain use of the second vehicle must encompass the fact that the second or older vehicle is reliable and a dependable means of transportation. Each of the proposals offered seems to meet this requirement. Section 1902(c), Title 38, United States Code gives the VA authority to "...provide, repair, replace or reinstall such adaptive equipment for any automobile or other conveyance which an eligible person may previously or subsequently have acquired." Our understanding is that S. 2210 would extend this authority to encompass the previously acquired vehicle retained by a veteran upon the acquisition of a newer vehicle. We presume that the contemplated compromise would also permit this.

RESPONSE OF THE PARALYZED VETERANS OF AMERICA TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. Sometimes around this place, we are faced with ideas and situations which have enormous emotional appeal. Yet, in this time of limited resources faced with enormous deficits, we need to take a hard look at what we are doing, what we want to do, and then, what we wpould like to do, but must postpone or deny. One of these appealing ideas is contained in a provision of S. 2269 which would authorize the VA to provide bereavement counseling services to family members of a deceased veteran if the family members were recipients of counseling services at the time of the veteran's death. The nature of counseling services provided to assist family members with emotional and psychological stress of death is quite different from counseling services provided before the veteran's death. Thus, the bereavement counseling provision in S. 2269 might be seen as a new service, no matter how meritorious its benefits, rather than as an eligibility question. What do you think about this distinction?

Answer 1. The proposal contained in S. 2269 to extend counseling services to certain survivors of deceased veterans is a most worthwhile effort. PVA supports such services because the needs and well-being of family members are inextricably tied to the services and sacrifices of individual veterans. This is particularly true in the case of catastrophically disabled veterans where family members have spent years caring for and supporting the veteran. The veteran's death is a traumatic time for the family and support services and counseling are critical elements in assisting family members in their readjustment.

Question 2. Last year we talked about moving the beginning date for the Vietnam era from its current date of August 5, 1964, to July 8, 1959. Each of you spoke in a way that reflected your appreciation of the several considerations of such a move. So, I would ask each of you again, what impact would the change in definition of the Vietnam era have on Vietnam veterans and how do your members no view the proposed change?

Answer 2. It would give proper recognition to those veterans who had served in Vietnam during our country's early involvement.

The impact of making this change would result in creating eligibility for a new group of Vietnam-era veterans. Two of the most significant changes we see that would be affected are the GI Bill, Chapter 34, and the non-service-connected pension. It could also result in eligibilities for various State benefits provided for Vietnam veterans, such as the Vietnam bonus.

Under the present system of defining wartime dates, there are inequities which harm those individuals who served in these and other situations. Two recent examples of where individuals served during dangerous and trying times are Grenada and Lebanon. It is PVA's view that those who served there but who were not injured deserve recognition as fully as do veterans who served during wartimes.

Furthermore, at least since the Korean conflict (and perhaps earlier) America's Armed Forces often have been in small but dangerous conflicts and hostile situations, or places on alerts to join our allies who are in wars and conflicts; therefore, the reasonable solution seems to be to abolish the wartime/peacetime dichotomy that denies pension eligibility to certain NSC disabled veterans.

Under the existing system an individual is likely to have served in a rigorous and danegrous situation but the coincidence of the dates service was rendered denies him or her benefits to which justice dictates that they qualify.

Question 3. S. 2269 proposes to expand eligibility for VA readjustment counseling to certain active duty military personnel within the limits of VA facilities. This raises for me two kinds of questions which I would ask each of you to address.

A. First, where is the division of responsibility between the VA and DOD? Should the VA, in the absence of a sharing agreement with DOD, treat active duty personnel in this manner?

B. Second, what is the meaning of the words "within the limits of Veterans' Administration facilities". The idea of making use of all of the capacity of the VA is good, but we all see problems of how to implement priority eligibilities at medical centers. Do we want to create the same problems in a program we already know is in high demand from veterans?

Answer 3A. The Veterans' Administration is responsible for all honorably discharged military personnel and their health care. The DOD should be responsible for their active duty personnel, up until date of discharge. In the absence of a sharing agreement the VA should not be expected to treat active duty personnel.

Answer 3B. We view readjustment counseling at Vet Centers to be "within the limits of Veterans' Administration facilities". These facilities are already operating at capacities that have created months of writing for much needed counseling by our already existing veteran population. Providing program eligibility for active duty personnel in Vet Centers would only exacerbate an already strained segment of the VA system.

Question 4. As you know, Public Law 95-202 provides for an administrative determination respecting whether the service of any non-military group or individuals was equivalent to, or tantamount to, active military service. This law has been implemented by the Department of Defense as the Defense/Civilian Review Board. A finding that service was tantamount to military service confers veteran status. What is the view of your members regarding the Defense/Civilian Military Review Board and what is your view toward providing Federal benefits for those whose service is not deemed to be tantamount to military service?

Answer 4. The precedent established by the passage of Public Law 95-202 confirming veteran status to members of the Women's Auxiliary groups who assisted in World War II is not synonymous with the issue of civilians who served in Vietnam. Even though DOD's Defense/Civilian Review Board has the administrative authority to issue a determination that one's non-military service is equivalent to, or tantamount to active military service, we feel that veteran status should be issued only in those cases where service was tantamount and then with serious reservation. The reason being--military service, in most cases, lacks the privilege of assignment choice as enjoyed by the civilians who served in Vietnam. To infer that the service of any civilians who served in Vietnam is equivalent to or paramount to military service thus deserving of veteran benefit status would at the same time confer a great disservice to those military personnel who without choice gave service and incurred injury.

Mr. **Principi.** Testimony from additional witnesses has been requested for the record by the chairman and without objection will be included in the published hearing record.

The committee stands adjourned.

[Whereupon, at 1 p.m., the committee was adjourned.]

[The committee received the following written statements and letters for the hearing record:]

PREPARED STATEMENT OF GWENYTH R. VAUGHN, PH.D., CHIEF OF AUDIOLOGY AND SPEECH PATHOLOGY SERVICE, VETERANS' ADMINISTRATION MEDICAL CENTER, BIRMINGHAM, ALABAMA

Mr. Chairman and Members of the Committee.

The Senate Veterans Affairs Committee has requested information concerning telecaptioning devices for veterans with profound hearing losses. I am offering my professional opinion as a chief of audiology and speech pathology in one of the many Veterans Administration Medical Centers.

Telecaptioning devices are only one of a number of assistive devices that are available for consideration by impaired veterans. Obviously, a need exists for telecaptioning, but the assistance given to the veteran is beneficial in only one situation.

I should like to take this opportunity to provide the Committee with some information about telecaptioning and also to offer some comments about the more general area of assistive listening devices.

Many people believe that any listening impairment can be overcome with just the use of a hearing aid. This is not true. A hearing aid does amplify sound, but there is a great different between hearing and understanding. A good example of this difference can be felt by even the normally hearing person while he or she is trying to talk with someone in a large cocktail party or restaurant. In this situation, most listeners may know that another person close by is talking, but the listeners have considerable difficulty in understanding what is being said.

The simple solution of just placing a hearing aid on the hearing impaired person is frequently not enough. The needs of the person may go beyond the capability of a personal hearing aid. Except for meeting an isolated need, the promotion of telecaptioning may not be the answer to the total communication needs of an individual.

If only telecaptioning, which is just one of a vast array of available assistive devices, is to be addressed by the Committee, there is some information that I should like to offer. Incidence statistics for the general population have shown that there are 18.7 million hearing impaired persons in the United States. Of these, 2 million have profound hearing losses.

The incidence of persons with a profound hearing loss within the VA is not as easily documented. It is possible to quickly determine the number of veterans who are receiving compensation from the VA for a service-connected hearing impairment, but there is still a large number of veterans with hearing impairments who cannot be identified. A hearing impairment is not one of the primary diagnostic medical codes, and, therefore, the data from these individuals is not easily retrievable. As a result, the number of veterans who ultimately may desire telecaptioning devices is difficult to predict.

When considering the use of a telecaptioning device, it is important that, in my opinion, at least three criteria should be utilized:

1. the veteran cannot benefit from the use of a hearing aid or an assistive listening device in order to view television,
2. the veteran is able to read and understand the captions, and
3. the veteran can benefit from a telecaptioning device as a part of his or her rehabilitation and personal and social well being.

The state-of-the-art technology offers mnay types of assistive listening devices and systems. In additional to conventional hearing aids, these devices may include hardwire, infrared, FM, loops, telecaptioning, and alerting devices. If being able to see the captions is a problem, there are several assistive devices that can improve the user's visual functions.

Assistive listening devices help overcome many of the listening problems encountered by hearing impaired persons who wish to listen to television, use the telephone, understand one-or-more talkers in a restaurant or other noisy environment, communicate on the telephone, or listen to speech or music in large areas such as houses of worship, lecture rooms, concert halls, and arenas.

I should like to suggest that after the need for medical and suugical treatment of the hearing loss has been ruled out, an audiologist should determine the appropriateness of recommending a telecaptioning device. If the screening of vision and reading reveals some problem, a vision specialist should be consulted.

If it is established that a veteran is so profoundly hard of hearing or deaf that a telecaptioning device is needed, other devices may be required, such as teletypewriters and alerting devices, including flashing lights or vibrators.

Hearing loss is a devastating condition. I am gravely concerned that we are allowing great numbers of veterans with moderate and severe service-connected hearing losses to face serious difficulties. Many of the veterans with hearing impairments are unable to hold jobs, keep up communication with their families and friends, or participate in community activities. One of their most serious problems arises when they cannot communicate effectively with their physicians and other members of the health care delivery teams, or with their religious advisors.

In the majority of cases, appropriate assistive listening devices could resolve these communication problems.

The Veterans Administration is dedicated to quality care and quality rehabilitation for hearing impaired veterans. It is my professional opinion that the provision of assistive listening devices to hearing impaired veterans could offer them the opportunity for the achievement and maintainance of the quality of life they deserve.

I wish to express my appreciation to Senator Simpson and the Members of the Senate Committee for permitting me this opportunity to speak in behalf of the many hearing impaired veterans.

PREPARED STATEMENT OF JOE COLLINS, EXECUTIVE DIRECTOR, CALIFORNIA ASSOCIATION OF ALCOHOLIC RECOVERY HOMES, INC., LOS ANGELES, CA

The Treatment and rehabilitation for alcohol or drug dependence or abuse disabilities Pilot Program enabled under Public Law 96-22, 1979, has proved itself highly cost-effective and recovery-effective (see attached reports by the California Association of Alcoholic Recovery Homes, and National Capitol Systems Incorporated/Associated Research Analysis Corporation). Both the national survey and study contracted by the Veterans Administration, and the California survey and study done independently, agree that for appropriate veterans, the services provided in community based alcoholism programs under contract with the Veterans Administration Health Facilities:

1. Cost about a tenth or less of inpatient services in VA facilities.
2. Produce equivalent, or better, alcoholism recovery rates insofar as statistical data is presently available.
3. Present a major potential for providing effective recovery services to presently unserved veterans, at no additional capital outlay to the federal government for additional VA facilities.
4. Allow veterans to obtain needed alcoholism recovery services in their own communities; veterans who would otherwise go unserved because of geographical remoteness, lack of available space in VA facilities, or procedural (paperwork) barriers within the bureaucracy.
5. Has significantly expanded the VA's ability to serve veterans needing alcoholism recovery services with no capital outlay, and at little or no additional personnel outlay.

RECOMMENDATIONS

A. The Pilot Program should be made a permanent part of the Veterans Administration overall Health Service Program.

All investigators have arrived at the same conclusion — the Pilot Program has shown itself to be a cost-effective, program-effective activity.

B. Rates for services should be established on the basis of actual costs in communities in which contracting facilities are located.

It goes without saying that costs of living vary greatly from rural to urban areas, and from one section of the nation to another. If equal quality services are to be provided, then allowance must be made for the differences in costs of providing services.

C. Criteria for quality of services and allowable length of stay in contracted facilities should be fully coordinated with State Alcoholism/Drug Authorities, most particularly where states have established quality assurance programs.

It makes little sense for the federal government to fund state alcohol and drug programs under the Alcohol, Drug Abuse, and Mental Health Administration block grants, and then to have the Veterans Administration propose quality standards which may be inconsistent or even in conflict with state standards. Is it inconceivable that the Veterans Administration might not just qualify local contract providers on the basis that a state has licensed and certified a program, when the federal government is already underwriting such quality assurance through Department of Health and Human Services funding? Is it necessary for the VA to independently create standards and quality assurance systems where states already have done the job?

1. The allowable length of stay of a veteran in a community based alcoholism recovery program should be studied and reassessed.

   Studies show that the present sixty day limit is simply inadequate for the veterans' needs. In the California study, the average stay for maximized recovery was eighty-nine days, even though the VA stopped paying after the sixtieth day.

D. The types of services provided under contracts should be expanded to at least include social model detoxification services.

It is well and fully established that most recovering alcoholics (including veterans) do not need to undergo initial withdrawal in a hospital setting, and in fact several reputable studies have shown that persons who detox in a social (nonmedical) setting achieve a higher proportion of full recovery than those who do not.

E. Eligibility procedures should be established which do not require that a veteran first enter a VA hospital or inpatient unit.

If a veteran is attracted to and is willing to enter a community alcoholism recovery program, he/she should be allowed to do so and then seek eligibility for payment. Many veterans are essentially denied services at a critical time because of problems of geographical location, nonavailability of bed space in VA facilities, or procedural (paperwork) delays. If a veteran were approved, the contract provider should be paid retroactively. If a veteran were not approved, the contract provider would have to accept the loss.

F. Followup studies and other analyses should be closely coordinated with state alcohol/drug authorities.

Re-inventing the wheel is costly. Nearly all states have effective programs and services in place to accomplish this kind of activity.

G. The words "halfway house" should everywhere be replaced with the phrase "recovery home/halfway house" which has become the proper generic term.

There are important perceptual and recovery-conducive aspects of the different phrase which impact on a person's acceptance of "full recovery" as contrasted with "half measures". As a matter of interest, the definition of "halfway house" presented in Senator Simpson's bill originated in the California Standards for Alcoholic Recovery Homes.

H. Serious consideration should be given to an appropriate, but fairly major expansion of funds allocated to contracts under this program.

Reports on the subject all show that large numbers of veterans with alcohol or drug problems are being denied services because of lack of VA bed space, geographical problems, and because many of the veterans recognize they have an alcohol or drug problem, but do not consider themselves sick enough to seek admission to a hospital. These are the same veterans who, if left unserved, will later come back with serious liver, pulmonary, cardiovascular, and a variety of other ailments. And then, because the alcoholism or drug problem has run its course unattended, the veteran will come forward and need a great deal of very costly medical and hospital attention.

CALIFORNIA ASSOCIATION OF ALCOHOLIC RECOVERY HOMES

VETERANS ADMINISTRATION PILOT PROGRAM SURVEY

SUMMARY REPORT

CALIFORNIA ASSOCIATION of
ALCOHOLIC RECOVERY HOMES
2146 W. Adams Boulevard
LOS ANGELES, CA 90018

BACKGROUND

During the months of October and November of 1983, the California Association of Alcoholic Recovery Homes surveyed 184 community based Alcoholism Programs throughout California to determine the programmatic benefits and cost effectiveness of the Veterans Administration's Pilot Program, authorized under Public Law 96-22, Section 104. This law calls for the Veterans Administration to contract with community based residential Alcoholism Recovery Homes and Halfway Houses to provide alcohol recovery and rehabilitation services to the chronic alcohol and related drug dependent veteran.

184 survey questionnaires were sent out to community based organizations operating alcohol recovery programs throughout California, (Refer to ADDENDUM I). 61 eligible organizations statewide responded to the questionaire. 15 or 25% of the respondent organizations indicated they were presently contracted with the Veterans Administration under the Pilot Program, (ADDENDUM II and III). Each of the 15 V.A. contractors indicated they were Certified by the California State Department of Alcohol and Drugs and Licensed by the Department of Social Services, Community Care section.

PROGRAMMATIC EFFECTIVENESS

The V.A. contracted programs surveyed, received a total of 214 referrals or admissions from the participating V.A. Hospitals during the 1982-83 fiscal year. The average V.A. reimbursement rate for each admission reported was $18.85 per residency day. The average length of stay reported for 214 admissions was 89 days. Length of stay ranged from 52 days to 210 days. Since the Pilot Program calls for a maximum reimburseable length of stay of 90 days, not all reported residency days were actually reimbursed by the V.A..

Public Law 96-22 indicates that the Pilot Program is designed to '...demonstrate any medical (programmatic) advantages and cost effectiveness that may result from furnishing such care and services to veterans...in contract facilities...'. The results of the CAARH survey indicates that the V.A. Pilot Program, designed to maximize the use of community based programs, providing a more appropriate 'continuum of care', is of substantial programmatic benefit to the individual veteran in terms of:

1) Alcoholism Recovery
2) Increased levels of functioning, ie. self-sufficiency.
3) Successful reintegration into the employment market.
4) Successful reintegration into the community.

As outlined below, the benefits are overwhelmingly indicated in the survey results. Of the 214 Veteran admissions received by the contracted programs during the fiscal year 1982-83:

67% Completed the residential alcohol program, making a planned re-entry into the community and independent living.

84% Of those Veterans that completed the program were reported as gainfully employed or otherwise self-sufficient.

65% Gainfully employed
19% Otherwise self-sufficient

69% Of those Veterans that completed the program were reported to be maintaining an ongoing sober life style.

COST EFFECTIVENESS

The Cost Effectiveness of the Pilot Program and V.A. use of community based residential Alcohol recovery facilities cannot be overstated. The V.A. use of contract programs minimizes the unnecessary and often repeated use of costly V.A. hospital care by the veteran with chronic alcohol and related drug dependencies by:

(1) Reducing the number of costly hospital inpatient days necessary to appropriately serve the veteran with alcohol problems, and providing less costly, programmatically beneficial, alternative community based contract services.

(2) Maximizing the use of a community based Continuum of Care which more effectively (than Regional Hospital Care) assists the veteran to successfully reintegrate into the employment market and community. Such successful reintegration has the potential of reducing costly repeat admissions to the V.A. Hospitals for alcohol and drug dependencies.

As stated previously, survey results indicated that the average length of stay per referral/admission in contracted facilities was 89 days with an average V.A. reimbursement rate of $18.85 per residency day. When compared with the cost of hospital inpatient

Care within the V.A. System of $95.00 per bed day for Alcohol and Drug Services, $140.00 per bed day for Inpatient detoxification Psychiatric and $264.00 per bed day for Medical ICU Services, the cost effectiveness of community based contracting is apparent:

28 days V.A. Inpatient Care @ $95.00(1) X 214 Admissions = $569,240
28 days Contracted Recovery Facility @ $18.85 X 214 Admissions = $112,949

The cost of V.A. Inpatient care is conservatively estimated at five times that of community based residential alcohol programs. Continued use and expended use by the V.A. of contracted community based facilities for eligible veterans can result in significant health care cost containment by the V.A. System, while simultaneously providing substantial recovery benefits to the veteran.

RECOMMENDATIONS

Based on the CAARH survey results indicating that:

I. The V.A.'s use of contracted Community Based Alcohol Recovery Programs is of substantial recovery benefit in terms of (1) Alcohol Recovery, (2) Establishing self-sufficiency, and (3) Reintegrating into the employment market and community. (These findings are consistent with the national findings of the National Capitol Systems Incorporated as reported to the Veterans Administration in the Interim Report 'Evaluation of the Veterans Administration Pilot Program To Provide Community Based Treatment For Alcohol or Drug Dependent Veterans' on February 1, 1983 (Addendum IV)), and

II. The cost of V.A. Inpatient Service is estimated to be five times that of Community Based Alcohol Recovery Programs, suggesting the potential for substantial Health Care Cost Containment within the V.A. Hospital system.

We recommend the following:

I. Establish the Pilot Program as a permanent program designating V.A. use of contracted Community Based Residential Alcohol Recovery Programs.

II. Increase the Unit Cost reimbursement to more appropriately accommodate the actual average unit cost per region (see Addendum III).

III. Extend V.A. reimbursement to cover actual length of program stay per veteran, in contracted facility.

IV. Establish a policy limiting the number of costly V.A. inpatient hospital days permitted for Treatment of Alcohol and Drug dependencies (excluding Medical Detox) per veteran per year, requiring as a more appropriate alternative the use of Community Based Alcohol Recovery Programs (2).

V. Extend V.A. reimbursement to cover other eligible Veterans who would like to utilize Community Based Alcohol Recovery Programs but are not presently in a V.A. Hospital Inpatient unit. Establish eligibility procedures that do not require entry into the regional V.A. detoxification and inpatient programs in order to be eligible for entry into V.A. reimbursed contracted services. (3)

VI. Explore additional areas of potential programmatic benefit and cost containment:

a. Establish a pilot program demonstrating the Cost Effectiveness and programmatic effectiveness of the V.A. use of contracted Community Based non-hospital (Social Setting) Alcohol Detoxification Centers (4).

FOOTNOTES:

(1) V.A. unit costs per Veterans Administration Central Office; Office of Alcohol and Drug Dependency.

(2) Community Based Programs often provide full service for primary recovery as well as for supportive recovery and re-entry services, thereby minimizing the need for Primary Treatment Services to be provided in an expensive hospital setting.

(3) Because of policy and procedural limitations as outlined in V.A. DM&S Circular 10-83-135 of August 19, 1983 (Addendum V), and due to practices of various V.A. Regional Programs many eligible veterans who would benefit by and would like to take advantage of the V.A. Pilot Program and contracted services cannot take advantage of V.A. reimbursement for contracted services due to the requirement of entry first into a hospital facility. There is often significant delay in being admitted to the regional V.A. Hospital Units due to geographical difficulties, processing time delays and lack of bed availability. This has resulted in the repeated inability of various referring agencies and Detox Centers to place veterans without financial resources in appropriate residential recovery facilities.

EXAMPLE: The Santa Rita Alcohol Information and Referral Program (operating in the Santal Rita Detention Facility, Pleasanton, Alameda County) serves the individual arrested for Public Drunkenness, and incarcerated in the Santa Rita Facility. 40% of this population are eligible veterans. Often an individual seeking help cannot be placed in the V.A. Hospital Unit in a timely manner. Nor can he/she be placed into a community based primary recovery program due to the lack of subsidized beds available. The individual veteran with limited resources, often, cannot pay modest Recovery Program fees. This results in a loss of program placement for hundreds of veterans each year. The V. A. Pilot Program policy effectively cuts off the veteran without financial resources from receiving community based recovery services.

(4) Studies by the Addiction Research Foundation indicate that the significant majority of the intoxicated alcoholic population do not require medical attention for safe withdrawal from alcohol. Studies further indicate that non-medical, peer supported homelike Detox Centers provide a programmatically effective and cost effective alternative to expensive hospitalization.
Social Setting Detox Centers, certified by the State of California, operate throughout the State. The State unit cost ceiling is $63 per day. This is in comparison to expensive and unnecessary V.A. hospitalization for intoxication with a unit cost range of $95.00 per bed day to $264.00 per bed day.

CALIFORNIA ASSOCIATION OF ALCOHOLIC RECOVERY HOMES

Veterans Administration Pilot Program Survey

NAME OF PROGRAM______________________________

ADDRESS OF PROGRAM______________________________

COUNTY______________________________

CONTACT PERSON______________________ TELEPHONE NUMBER______________

(1) Is the above Program classified as

__________Detox __________Halfway House

__________Recovery Home __________Other (Please Describe)

(2) Is your Program (or Corporation)

	Yes	No
(a) A CAARH member	_____	_____
(b) Licensed by State-Community Care Licensing	_____	_____
(c) Certified by State Dept. of ADP	_____	_____

(3) What were your total Admissions for 1982-1983?

Detox________ Recovery Home________ Halfway House________

(4) How many of your total Admissions for 1982-83 were veterans?

Detox________ Recovery Home________ Halfway House________

(5) How would you describe your working relationship with the V.A. Hospital nearest you?

Excellent_____ Good_____ Fair_____ Non-Existant_____

Briefly Describe:______________________________

____

____

(6) Do you currently have a reimbursement contract for services with the Veterans Administration? Yes_____ No_____

If you answered Yes to Number (6) please complete (7) through (17).

(Over)

ADDENDUM I

(7) Through which V.A. Hospital do you contract?

Name______________________ County________________________

(8) What services does your contract cover?

Detox________ Recovery Home________ Halfway House________

(9) Does your contract cover... Man Only_____ Women Only____ Both____ ?

(10) How much are you being reimbursed per residency day under this contract?

____

(11) What is your actual cost per residency day?____________

(12) How many referrals (admissions) did you receive under your V.A. contract in 1982-83?__________

(13) What was the average length of stay of these admissions?__________

(14) How many of these admissions completed your program or had a planned exit?

____

(15) Of the above admissions who had a planned exit, how many have maintained their sober life style since departure?____________

(16) Of the above admissions who had a planned exit, how many are:

Gainfully Employed?____________

Otherwise Self Sufficient?____________

(17) Further Comments regarding your V.A. Contract?

____

____

____

Thank you! Thank you! Thank you!

Please Return Survey to CAARH Office in enclosed envelope.

Thank you

ADDENDUM I

SURVEY RESPONDENTS

	PROGRAM RESPONDENTS	COUNTY	V.A. CONTRACT
1.	Crossroads Foundation	San Diego	Yes
2.	Social Science Service Inc.	San Bernadino	No
3.	Mini Twelve Step House Inc.	Los Angeles	No
4.	Van Ness Recovery House	Los Angeles	No
5.	Bishop Gooden Home	Los Angeles	Yes
6.	Little House	Los Angeles	No
7.	Alcohol Center Teenagers Inc.	Tulare	No
8.	Indian Growth Center	San Diego	Yes
9.	North County Serenity House Inc.	San Diego	No
10.	Corner Stone Outreach Inc.	Orange	No
11.	Rancho Laguna Seca Inc.	Santa Clara	No
12.	Alton Rehabilitation Center	Los Angeles	No
13.	Palm Ave. Social Setting Detox	San Mateo	No
14.	Benny McKeown Center	Santa Clara	No
15.	Amador Council on Alcoholism Inc.	Amador	No
16.	Alcoholism Council of Sierra Nevada	El Dorado	No
17.	Pine Manor Recovery Center	Tulare	Yes
18.	PAAR Center	Tulare	Yes
19.	Casa de los Amigos	Los Angeles	Yes
20.	Step House of Santa Ana	Orange	No
21.	Comprehensive Alcohol Program	Fresno	No
22.	Sun Street Center	Monterey	No
23.	Myrtle's Alcoholism Recovery Home Inc.	Sacramento	No
24.	Oliver House of St. Vincent De Paul	San Francisco	No
25.	Golden Gate For Seniors	San Francisco	No
26.	Phoenix House Inc.	Shasta	No
27.	San Francisco Women's Rehab Foundation Stepping Stone	San Francisco	No
28.	Henry Ohlhoff House	San Francisco	No
29.	Duffy's	Napa	No
30.	Aware Program/New Way Foundation	Los Angeles	No
31.	Parro Rama Ranch	San Bernadino	No
32.	Middle House	San Luis Obispo	No
33.	Stepping Stones Home	Los Angeles	No
34.	New Way Foundation	(Burbank)	No
35.	Tradition Twelve Inc	Imperial	No
36.	Door To Hope	Monterey	No
37.	Four Winds Lodge/Indian Center	Santa Clara	No
38.	The Fellowship Center Inc.	San Diego	Yes
39.	Path Finders of San Diego Inc.	San Diego	Yes
40.	Crossroads of Covina	Los Angeles	No
41.	Sonoma County Alcohol Services	Sonoma	No
42.	Western Addiction Services	Santa Barbara	No
43.	South Coast Counseling	Orange	Yes
44.	Eureka 12th Step House Inc.	Humboldt	No
45.	Fulton Fellowship House	Sonoma	No

Addendum II

	PROGRAM	COUNTY	VA CONTRACT
46.	Alpha House Inc.	Fresno	Yes
47.	Salvation Army Harbor Light Service	San Francisco	No
48.	West Oakland Health Center	Alameda	No
49.	Glenwood House Inc.	Orange	No
50.	Beamer Street	Yolo	No
51.	The Villa	Orange	No
52.	Harnard Halfway House	Los Angeles	No
53.	Kern County Alcohol Center	Kern	No
54.	Mid Valley Recovery Facilities(Pathways)	Yuba	Yes
55.	San Joaquin County Recovery	San Joaquin	No
56.	Project Ninety Inc.	San Mateo	No
57.	Hope Haven Inc.	Santa Cruz	No
58.	Alpha Oaks	Sacramento	No
59.	East County Detoxification	Contra Costa	No
60.	Sunrise House Inc.	Contra Costa	Yes
61.	Casa Solano Inc.	San Luis Obispo	No
62.	South Placer Recovery Program	Placer	Yes
63.	Tahoe Sierra Council	Placer	Yes
64.	ARA First Step	San Francisco	No
65.	Bi-Bett Alcohol Program	Contra Costa	Yes

Sixty one of the sixty five Survey respondents are eligible residential alcoholism Recovery Homes, Treatment Programs or Halfway Houses. Four provide Alcohol Detox or Referral services only.

2-84

Addendum II

CONTRACTORS INFORMATION

15 community based residential alcohol recovery programs indicated they were contracting through the following V.A. hospitals:

San Diego	4
Los Angeles (Brentwood)	2
Long Beach	1
Fresno	3
Contra Costa	5
Total	15

Contracts were for services to male and female veterans as follows:

Men's Facilities	7
Women's Facilities	3
Co-ed Facilities	5
Total	15

Contracted Reimbursement Rates varied from $17 - $25 per day

10 contracts at	$17.00	Contra Costa, San Diego, Fresno
1 contract at	19.63	Fresno
1 contract at	21.00	Long Beach
1 contract at	23.00	Fresno
2 contracts at	25.00	Brentwood. Los Angeles

Survey results indicate that V.A. Reimbursement Rates varied. Occasionally they were less than Contractors Actual Unit Cost. Actual Unit Cost ranged from $12.50 per day to $35.00 per day.

Addendum III

INTERIM REPORT

EVALUATION OF THE VETERANS ADMINISTRATION PILOT PROGRAM TO PROVIDE COMMUNITY BASED TREATMENT FOR ALCOHOL OR DRUG DEPENDENT VETERANS

on

Contract Number
V101(93) P-818 SB-3-4-0-8(a)-81C-0835

Submitted to:

THE VETERANS ADMINISTRATION

February 1, 1983

by

NATIONAL CAPITOL SYSTEMS INCORPORATED

Suite 310, 1900 L Street, N.W.
Washington, D.C. 20036

(202) 659-9383

and

ASSOCIATED RESEARCH ANALYSIS CORPORATION

Suite 414, 10560 Main Street
Fairfax, Virginia 22030

(703) 385-2920

Addendum IV

I. Conclusions

We have continually stressed that, due to research limitations, a true control population was not attainable; however, the resulting comparison patient population does provide valuable information about the treatment process when compared with the study patient population. All the findings presented in this interim report on the pilot program point to a few major conclusions:

- The study and comparison patient populations are more seriously ill than the alcohol and drug dependent treatment population as a whole. Moreover, the study patient population is more seriously ill than the comparison patient population.
- The VA patients that accept and complete extended halfway house treatment have made significant advances in all employment measures and in reducing their alcohol and drug use as well as other measures.
- Although the comparison patients were assessed as having less serious problems at both admission and follow-up than the study patients, the overall extent of improvement was greater for the study patients.
- The results of the "Block Cluster Analysis" show the utility of multivariate analysis for identifying individuals who may be more or less suitable for various types of treatment, and they yield unique characterizations of patients which may partially explain the success or failure of treatment modalities.
- The data suggests that with the receipt of additional follow-up reports a more suitable control patient population can be developed. This would involve comparing study patients who completed their halfway house program with three other groups of patients.
  - Patients who entered a halfway house but did not complete the program,
  - Patients who wanted to enter a halfway house but could not, and
  - Patients who did not want to enter a halfway house.

  Preliminary data, some of which is not addressed in this report, strongly indicates that when compared as suggested above, the halfway house program has a major positive impact on those who complete their program.

9. Guidelines for Selection for Post-Hospital Referral

It should be emphasized that this program is limited to out-placement of eligible veterans who have recently completed detoxification or other hospital level treatment. The program is not intended for use as an emergency boarding house, nor as a way-station for veterans headed for domiciliary placement, nor for treatment prior to hospitalization or rehospitalization. Technical (clinical) guidance, patient selection, and associated coordination will be provided by the Office of the Chief, ADTP, or DDTP, at the contracting VA medical center. When there is no ADTP or DDTP at the VA facility, these functions will be provided by the physician who has major responsibility for the VA treatment of such cases.

a. Placement in Residential Facility:

(1) As specified above, all such out-placements should be capable of self-preservation. In an emergency situation, the patient should have sufficient capacity to recognize physical danger, sufficient judgment to recognize when such danger requires immediate egress from a group residence, sufficient capacity to follow a prescribed route of egress, and sufficient physical mobility to accomplish such egress.

(2) Patients who, for various reasons, need a slower integration into the community, perhaps requiring a low-skilled job and some help finding a room with cooking privileges.

(3) Alcohol or drug abusing veterans who, because of health problems, may find readjustment to "street life" tough going, and who may need additional time and support in order to be self-supportive.

(4) The alcohol or drug dependent veteran who has an unsatisfactory home environment may need more time to stabilize the changes made in the inpatient unit, before living autonomously or returning home.

(5) The semi-stable individual who has considerable ego strength and some environmental support, but due to a crisis, needs a brief stay in a residential setting and requires a therapeutic milieu.

b. Placement in Outpatient Treatment Facility:

This option applies to veterans who have available residential support and/or employment in a location sufficiently distant from a VA treatment facility, that participation in a VA outpatient treatment program is not feasible: Such out-placements should reflect sufficient prior collaborative planning with the non-VA program as to assure continuity of treatment activities and general endorsement of VA treatment goals.

PREPARED STATEMENT OF JACK J. DACK, LEGISLATIVE CHAIRMAN, NATIONAL ASSOCIATION OF STATE VETERANS HOMES

POSITION OF NATIONAL ASSOCIATION OF STATE VETERANS HOMES IN OPPOSITION FOR THE NEED FOR LEGISLATION TO PROVIDE A TECHNICAL AMENDMENT, SECTION 8, SUBSECTION (b) OF SECTION 5035, TITLE 38, OF THE UNITED STATES CODE WHICH WOULD:

"REQUIRE THE ADMINISTRATOR OF THE VETERANS ADMINISTRATION TO DEVELOP CRITERIA PURSUANT TO WHICH APPLICATIONS FOR GRANTS FOR CONSTRUCTION, REMODELING, EXPANSION, OR ALTERATIONS OF STATE VETERANS HOME FACILITIES CAN BE AWARDED ON A BASIS OTHER THAN FIRST-COME, FIRST-SERVED."

S-2269

SENATE VETERANS AFFAIRS COMMITTEE

4-2-84

4-2-84

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

S-2269

VETERANS ADMINISTRATION HEALTH-CARE PROGRAM IMPROVEMENT ACT OF 1984

Mr. Chairman, Distinguished Members of the Senate Veterans Affairs Committee, the National Association of State Veterans Homes appreciates this privilege to express opposition for the need for Legislation to provide a technical Amendment, Section 8, Subsection (b) of Section 5035, Title 38, of the United States Code, which would:

> "Require the Administrator of the Veterans Administration to develop criteria pursuant to which applications for grants for construction, remodeling, expansion, or alterations of State Veterans Home Facilities can be awarded on a basis other than first-come, first-served."

The State Veterans Home Program has grown from eleven homes in eleven states in 1838 to presently fifty-two homes in thirty-four states. Nursing Home Care is provided in forty homes, Domiciliary Care in thirty-nine homes, and Hospital Care in six homes. These Homes presently have over 17,000 beds; and, in the Fiscal Year 1983, provided more than 4.3 million days of care. The State Veterans Home Program is an acknowledged, cost-effective alternative to providing long-term health services in Veterans Administration facilities.

The State Home Construction Grant Program began with the passage of PL 88-450, on August 19, 1964, which authorized Nursing Home Care. In addition to setting a per diem rate of $3.50 for State Nursing Home Care, the Act authorized a five-year program, supported by an appropriation of $5 million per year for Grants to states for construction of Nursing Home Care Facilities. The Veterans Administration could participate in such Grants up to 50 per cent of the cost of construction.

Subsequent Legislation which significantly changed the Construction Grant program is as follows:

a) 1969, PL 91-178: Expanded Grants for States for assistance in remodeling, modification, or alterations of existing Hospital or Domiciliary facilities in State Homes providing care and treatment for Veterans.

b) 1973, PL 93-82: Changed the participation rates from 50 per cent to 65 per cent and limited beds to two and one-half per 1,000 Veterans population of the state.

c) 1977, PL 95-62: Redefined construction to mean new Domiciliary and Nursing Home buildings and expansion, remodeling and alteration of existing buildings for the provision of Domiciliary Nursing Home Care or Hospital Care in State Homes and the provision of initial equipment to furnish such buildings.

This Act changed the Veteran occupancy requirement in State Veterans Homes receiving a Construction Grant from 90 per cent to 75 per cent.

This Act also changed the amount that any one state may receive in any Fiscal Year to one-third of the amount appropriated in such Fiscal Year.

d) 1979, PL 96-151: Removed the $15 million limitation for authorized amounts for Construction Grants.

e) 1980, PL 96-330: Removed the legal limitation of two and one-half beds per 1,000 Veteran population in a state and left to the Veterans Administration Administrator to prescribe the number of beds required to provide adequate Nursing Home Care to Veterans residing in each state. Regulations have established a ceiling of four beds per 1,000 Veterans with justification required if construction would result in nursing home beds in excess of two and one-half beds per 1,000 Veterans in each state.

Appropriated amounts since Fiscal Year 1975 for Construction Grant Programs are as follows:

FISCAL YEAR	AMOUNT (000,s)
1975	$ 9,700
1976	$10,000
1977	$10,000
1978	$15,000
1979	$10,000
1980	$ 7.500
1981	$15,000
1982	$15,840
1983	$18,000
1984	$18,000
1985	$34,500 (requested)

From Fiscal Year 1966 through January 31, 1984, $169,040,000 has been appropriated for Grants for Construction of State Extended Care Facilities. Of these monies, $128,371,314 have been obligated, involving 1,215 Domiciliary Beds, 5,673 Nursing Beds, as well as projects for renovations, life safety, etc. Thirty-three states have received Grants covering 138 different projects, with the total estimated cost of $222,483,995, resulting in Federal participation of an overall 58 per cent of the estimated cost of the projects. (Source - Veterans Administration, 1984)

States Without Veterans Homes are:

Alabama

Alaska

Arizona

Delaware

Florida - awaiting funding

Hawaii

Kentucky

Mississippi - awaiting funding

Nevada

New Mexico - in process

North Carolina

Oregon

Tennessee

Texas

Utah

Virginia

Eligible preapplications and applications for Grants for Construction of State Extended Care Facilities approved/pending approval as of January 31, 1984, reflect an estimated Grant request of $119,742,000. The Fiscal Year 1984 funding of eighteen million dollars will reduce the backlog of projects to $101,742,000. (For listing see Appendix 1)

The eligible construction/renovation projects as of January 31, 1984, funded for Fiscal Year 1984 and planned for obligation beyond, involve 455 Domiciliary Beds, 56 Hospital Beds, 2,309 Nursing Care Beds and projects for life/safety, privacy, etc.

To provide a technical Amendment to Section 5035 of Title 38, United States Code, to require the Administrator to issue regulations setting forth criteria by which Grant Applications would be rated, and then in any year in which the value of approvable Grants exceeds the funds appropriated for such purposes, to award such Grants in accordance with the priority, would be a departure from the existing tested and effective system of fund allocation on a "first-come, first-serve" basis. The National Association of State Veterans Homes has looked at priorities over the years; however, the one process which exhibits no favoritism is on a "first-come, first-serve" basis. It has not been the "first-come, first-serve" method of awarding Grants that has been the problem. The problem has been inadequate funding of the Construction Grant Program.

The need for State Home Facilities is determined by the state and by the area-wide clearinghouses, Certificate of Need, etc., in the states applying for Grants. Most existing State Homes also coordinate such projects with Veterans Administration Medical Districts in the planning process. To further complicate the picture by adding additional federal criteria would be a duplication of effort and expense. For a state to be positively assured when funding will be available is critical in planning. It seems to take several years for states to become interested in entering the Program or in upgrading present facilities to meet the ever-pressing Regulatory Agencies' requirements. Requiring the Veterans Administration to prioritize based on such manipulable factors "as the demand in the Veterans Administration for nursing home care and domiciliary care as appropriate, for Veterans eligible for such care in the geographic areas concerned," etc., would eliminate the current predictability of fund flow for states in the Program. It would pit state against state, Congressional Delegation against Congressional Delegation and politicize a currently rational, predictable program operation. Such uncertainty or changes in priorities will discourage, particularly, new states from participation.

Veterans Administration Regulations already outline additional criteria the Administrator utilizes in the awarding of Grants if a state desires to build more than two and one-half beds per thousand Veteran population within the state, not to exceed four beds per thousand Veteran population. (Title 38, U.S.C. 5034(1), See Appendix 2 for Regulations).

In summary, the membership of the National Association of State Veterans Homes recommends continuation of the "first-come, first-serve" method of awarding matching grants to states for the construction, remodeling or renovation of State Veterans Homes which has worked well both for the Veterans Administration and the states. Why change a good system that has been proven effective for 19 years?

To improve the effectiveness of this matching program, we believe the following recommendations are worthy of consideration:

(A) Fiscal Year 1984 funding be authorized at $34.5 million and this level be maintained as long as necessary to eliminate the current backlog of state home construction projects.

(B) Establish a provision for one-time funding of new states coming into the Program from Veterans Administration Construction Funds. To fund construction of a State Home in a state without a facility would be less costly than Veterans Administration construction. The maximum cost to the Federal Government cannot exceed 65 per cent of the estimated construction costs. Construction and operation of State Home nursing care beds over the years has historically cost far less than Veterans Administration comparable programs.

Thank you, Mr. Chairman, for allowing us to present this testimony.

Jack J Dack

Jack J. Dack, Legislative Chairman
National Association of State
Veterans Homes
Commandent, Iowa Veterans Home
Marshalltown, Iowa 50158

APPENDIX 1

ELIGIBLE PREAPPLICATIONS AND APPLICATIONS FOR GRANTS FOR CONSTRUCTION OF STATE EXTENDED CARE FACILITIES (PENDING APPROVAL)

(Dollars in thousands)

January 31, 1984

FAI No.	State (locality)	Project	Estimated Grant Request
24-003	MD (Charlotte Hall)	New State Home (3rd Phase-126 Dom/NH Beds)	$ 7,904
24-004	MD (Charlotte Hall)	New State Home (4th Phase-126 Dom/NH Beds)	4,195
08-007	CO (Rifle)	New State Home-100 NHC Beds	2,426
31-005	NE (Scottsbluff)	50-Bed NHC Wing & Renovations	1,560
42-006	PA (Hollidaysburg)	Boiler Plant Modifications	488
17-005	IL (Manteno)	New State Home-300 Bed NHC	11,828
17-007	IL (Quincy)	Renovation Andrew	351
17-008	IL (Quincy)	Energy Conservation	117
35-001	NM (T or C)	New Home-53 Dom, 133 NH Beds	2,990
09-008	CT (Rocky Hill)	Window Replacement	584
17-009	IL (Quincy)	Fire Safety	111
19-025	IA (Marshalltown)	Renovate Loftus-NH-Life Safety	365
50-006	VT (Bennington)	50 Bed NH Care & Renovations	3,250
26-002	MI (Grand Rapids)	Replacement of Mann Building-226 NH Beds	10,972
06-008	CA (Yountville)	Hospital Addition-56 Beds	5,605
06-009	CA (Yountville)	Remodel Dom - C	1,636
06-010	CA (Yountville)	Remodel Dom - A	1,317
06-011	CA (Yountville)	Cooling Plant and Piping	1,359
26-003	MI (Marquette)	New State Home 155 - Bed Conv to NH	2,247
34-009	NJ (Paramus)	New State Home-300 Bed NH	13,000
28-001	MS (Jackson)	New State Home-150 Bed NH	4,388
30-002	MT (Columbia Falls)	50 - Bed NH Wing	1,203
25-029	MA (Chelsea)	Elevators	78
25-030	MA (Chelsea)	Renovations	76
06-012	CA (Yountville)	Remodel Hospital Ward 1A	118
37-N003	PA (Hollidaysburg)	Renovations-NHC-Grant Increase	99
37-N004	PA (Hollidaysburg)	Renovations-DOM-Grant Increase	191
13-004	GA (Milledgeville)	150 Bed NH	5,902
27-006	MN (Hastings)	Grant Increase	474
17-010	IL (Quincy)	Life Safety-Fire Alarm	144
42-008	PA (Hollidaysburg)	Renovation-Sommer-225 NH Beds	2,785
06-013	CA (Yountville)	Rem. Sec. B to NH-Life Safety	2,179
06-014	CA (Yountville)	Rem. Sec. D Dom-Life Safety	1,680
06-015	CA (Yountville)	Rem. Sec. E Life Safety	1,729

APPENDIX 1

Page 2

FAI No.	State (locality)	Project	Estimated Grant Request
06-016	CA (Yountville)	Ren. Hospital Support Service	$ 1,300
06-017	CA (Yountville)	Ren. Nursing Home	1,557
06-018	CA (Yountville)	Ren. Sec. F - Handicapped	1,299
06-019	CA (Yountville)	Ren. Workshop-Sprinkler	98
36-002	NY (Long Island)	New 350 Bed NH	11,375
06-020	CA (Yountville)	Ren. Sec. H Dom-Fire & Safety	1,105
06-021	CA (Yountville)	Ren. Sec. J Dom-Fire & Safety	1,105
06-022	CA (Yountville)	Ren. Sec. K Dom-Fire & Safety	1,105
06-023	CA (Yountville)	Ren. Sec. L Dom-Fire & Safety	1,105
06-024	CA (Yountville)	Ren. Wings 1C-D, 2C-D, 3C-D NH-Fire & Safety	1,557
05-002	AR (Little Rock)	Conversion 70 Dom beds to NH	195
42-009	PA (Hollidaysburg)	Renovate Dietary Building to serve 427 NH & 179 Dom	722
44-003	RI (Bristol)	Domiciliary Renovation	1,138
12-001	FL	New State Home 150-bed Dom	2,730
			$119,742

APPENDIX 2

TITLE 38, U.S.C. 5034(1)

6171 (§17.171). (MAXIMUM NUMBER OF) NURSING HOME BEDS REQUIRED FOR VETERANS BY STATE

(A) For purposes of these regulations, Appendix A prescribes the (maximum) number of beds (which may be necessary) to provide adequate nursing home care to veterans residing in each State. (When the beds to be constructed in a State will result in more than two and one-half beds per 1,000 veterans, the State shall provide sufficient justification for the Administrator to determine that the additional beds are required in that State. In making this determination, the Administrator shall consider the following factors:

(1) Demographic characteristics of the State's veteran population,

(2) Availability, suitability and cost of alternative nursing home beds to meet the needs of veterans in that State,

(3) Waiting lists for existing State nursing home facilities and

(4) Any other criteria which the Administrator shall deem appropriate to provide adequate nursing home care).

(PL 88-450, sec. 4(a) as amended by PL 89-311, sec. 7(b): PL 93-82, sec. 403(d); PL 94-581, sec. 206(b); (PL 96-330, sec. 404;) U.S.C. 5034(1)) (Dec. 23, 1982) (Veterans Administration Regulations Medical Transmittal Sheet 145, Veterans Administration, Washington, D. C., December 23, 1982)

APPENDIX 2 - PAGE 2

APPENDIX A--(§ 17.171) TITLE 38, U.S.C. 5034(1)

State	Veteran population	Number of beds
Alabama	436,000	1,744
Alaska	50,000	200
Arizona	383,000	1,532
Arkansas	270,000	1,080
California	3,003,000	12,012
Colorado	401,000	1,604
Connecticut	413,000	1,652
Delaware	77,000	308
District of Columbia	65,000	260
Florida	1,392,000	5,568
Georgia	632,000	2,528
Hawaii	99,000	396
Idaho	121,000	484
Illinois	1,348,000	5,392
Indiana	680,000	2,720
Iowa	354,000	1,416
Kansas	300,000	1,200
Kentucky	405,000	1,620
Louisiana	453,000	1,812
Maine	154,000	616
Maryland	544,000	2,176
Massachusetts	720,000	2,880
Michigan	1,117,000	4,468
Minnesota	525,000	2,100
Mississippi	245,000	980
Missouri	647,000	2,588
Montana	108,000	432
Nebraska	191,000	764
Nevada	137,000	548
New Hampshire	138,000	552
New Jersey	925,000	3,700
New Mexico	162,000	648
New York	1,951,000	7,804
North Carolina	660,000	2,640
North Dakota	69,000	276
Ohio	1,385,000	5,540
Oklahoma	397,000	1,588
Oregon	400,000	1,600
Pennsylvania	1,593,000	6,372
Rhode Island	126,000	504
South Carolina	351,000	1,404
South Dakota	80,000	320
Tennessee	543,000	2,172
Texas	1,732,000	6,928
Utah	155,000	620
Vermont	64,000	256
Virginia	664,000	2,656
Washington	628,000	2,512
West Virginia	243,000	972
Wisconsin	574,000	2,296
Wyoming	67,000	268

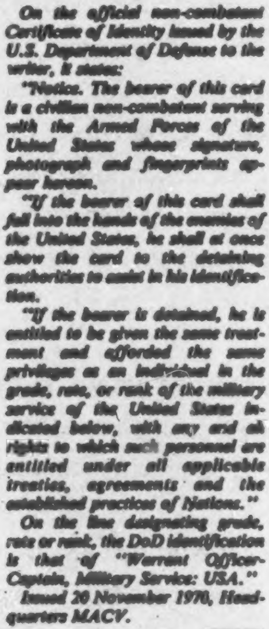
Estimate as of March 31, 1983. Source: Office of Reports and Statistics, Veterans Administration, (Based on last available Census data-June, 1983)

PREPARED STATEMENT OF JOAN M. MAIMAN, VIETNAM CIVILIAN VOLUNTEER, CHICAGO, IL

This nation was founded on the concept that every citizen has a responsibility to serve if called on to do so to preserve the common freedoms which we enjoy.
Believing in this ideal, there were those of us who volunteered to serve in Vietnam as civilians in support of the U.S. military effort there during the Vietnam conflict.
It is estimated that some 10,000 persons served in this capacity with agencies such as the Red Cross and the USO.
In many cases our living conditions and exposure to toxic elements and combat hazards were identical to that of the military with whom we were stationed.
Yet, we now find that we are totally excluded from any programs to address the possible effects of agent orange exposure or stress related illness whichmay arise from such service.
Indeed, I have had civilians who served with the Red Cross and the USO advise me that they have been denied any assistance when they have sought help at the VA outreach centers for problems they contend arise from their service in Vietnam.
To date, none of the agencies of government have taken any steps whatever to provide tangible assistance to those who served this nation as volunteers in Vietnam. We are told that our concerns are not within their jurisdiction.
The only action to come on our behalf has come on a state level.
Governor James Thompson has appointed me as a commissioner on the IL Agent Orange Study Commission as an expression of his concern and that of the state for the non combatants .
Resolutions are before the IL General Assembly calling for our inclusion in potentially life saving screening programs for dioxin exposure as well.
Other states (California) have legislation pending to help their civilians also.
Clearly, however, the solution must lie infederal action.
Thus, while I welcome the interest of this body in our concerns

I believe this S. 2269 does not address the needs of such persons in a substantive manner. There is a need for immediate programs for those who have waited far too long for their government to respond.

I would remind you that as civilians serving with the armed forces in Vietnam we drew hostile fire pay and carried Department of Defense identification which read as follows:



On the official non-combatant Certificate of Identity issued by the U.S. Department of Defense to the writer, it states:

"Notice. The bearer of this card is a civilian non-combatant serving with the Armed Forces of the United States whose signature, photograph and fingerprints appear hereon.

"If the bearer of this card shall fall into the hands of the enemies of the United States, he shall at once show the card to the detaining authorities to assist in his identification.

"If the bearer is detained, he is entitled to be given the same treatment and afforded the same privileges as an individual in the grade, rate, or rank of the military service of the United States indicated below, with any and all rights to which such personnel are entitled under all applicable treaties, agreements and the established practices of Nations."

On the line designating grade, rate or rank, the DoD identification is that of "Warrant Officer-Captain, Military Service: USA."

Issued 20 November 1970, Headquarters MACV.

If there is to be a resolution to the concerns of those who served in Vietnam, such resolution must include those who volunteered to serve as non combatants.

For if we fail to do so, who indeed will volunteer to step forward to answer the call of the nation in time of need as we did?

Joan M. Maiman
300 N. State
3409
Chicago, IL 60610
Vietnam Nov. 1970-71
24th Evacuation Hosp.
American Red Cross

PREPARED STATEMENT OF MAUREEN E. NERLI, VIETNAM CIVILIAN VOLUNTEER, BURLINGAME, CA

IT SEEMS ALL TOO EASY TO FORGET THE DEDICATED AND COURAGEOUS ROLE OF THE 10,000 AMERICAN WOMEN WHO VOLUNTEERED FOR CIVILIAN SERVICE IN VIETNAM WITH THE U.S.O., AMERICAN RED CROSS AND OTHER AGENCIES. WHY MUST OUR PART IN THE VIETNAM CONFLICT BE REMEMBERED UNDER "MISCELLEANOUS" IN HISTORY BOOKS? WHEN THE GOING WAS TOUGH, WHEN OUR COUNTRY NEEDED US, WE FORGOT THE RISK, THE DANGER AND VOLUNTEERED FOR SERVICE. DESPITE OUR PERSONAL OPINIONS OF THE WAR, WE WERE THERE TO HELP IN ANY WAY WE COULD. THERE WAS A JOB TO DO AND WE GLADLY DID IT. MANY OF THESE WOMEN, IT MUST BE NOTED, HAD TO PAY FOR THEIR OWN AIRFARE TO VIETNAM. THE MONEY WAS TAKEN OUT OF THEIR MONTHLY PAYCHECKS. SUCH VALOR MUST NOT CONTINUE TO BE IGNORED. RECOGNITION FOR A SERVICE IN VIETNAM MUST BE OUR MEDAL OF HONOR. IT IS LONG OVERDUE, GENTLEMEN, LONG OVERDUE.

ARE WE IGNORED BECAUSE WE ARE NOT CLASSIFIED AS VETERANS IN THE FEDERAL MEANING OF THE TERM? WELL, THEN, GIVE US VETERANS STATUS AND THAT PROBLEM WILL BE SOLVED. WHY SHOULDN'T WE RECEIVE THAT STATUS, WE SERVED OUR COUNTRY DIDN'T WE?

MANY OF THE WOMEN CIVILIANS ARE TODAY SUFFERING FROM PHYSICAL AND EMOTIONAL PROBLEMS AS A DIRECT RESULT OF THEIR EXPERIENCES IN VIETNAM, TO INCLUDE SPRAYING OF AGENT ORANGE. WHY HAS IT TAKEN OUR GOVERNMENT SO LONG TO RECOGNIZE THIS ISSUE? CERTAINLY IT IS NOT BECAUSE OUR RESPECTIVE AGENCIES ARE NOT PART OF THE MECHANICS OF OUR GOVERNMENT TODAY. MANY OF YOU ARE MEMBERS OF THE BOARD OF DIRECTORS OF THE U.S.O. AND AMERICAN RED CROSS. CERTAINLY YOU MUST BE COGNIZANT OF THE RESPECTIVE AGENCY'S EFFORTS IN VIETNAM. WHY THEN ARE THE PERSONNEL WHO SERVED THESE AGENCIES COMPLETELY IGNORED? WHEN WE REACH OUT FOR HELP, WE ARE TOLD WE ARE NOT VETERANS SO LOOK ELSEWHERE FOR HELP. I FIND THAT OFFENSIVE TO THE PERSONAL DIGNITY OF EVERY CIVILIAN WOMAN (AND MAN) WHO SERVED IN VIETNAM.

ONLY YOU CAN CHANGE THAT ACT OF DISCRIMMINATION, GENTLEMEN. YOU MUST ALSO REMEMBER THAT WHEN WE SERVED IN VIETNAM WE RECEIVED THE DEPARTMENT OF DEFENSE IDENTIFICATION THAT IN ESSENCE READ:

> ".(SHE)....is a civilian non-combatant serving with the Armed Forces of the United States............. designating grade, rate or rank, the DOD identification is that of Warrant Officer-Captain, Military SErvice: USA."

IF, THEN, OUR SERVICE WAS OF A MILITARY NATURE, WHY MUST WE FACE DISCRIMMINATION IN APPLYING FOR FEDERAL SERVICE POSITIONS? WE ARE NOT GIVEN POINTS FOR MILITARY SERVICE, AND ARE PLACED ON LOW PRIORITY FOR POSITIONS MOST OF US ARE QUALIFIED TO PERFORM. I FIND THAT OVERSIGHT INEXCUSEABLE. WE SHOULD BE GIVEN STATUS FOR SERVICE IN VIETNAM, TOTALLY WITHOUT RESERVATION.

IN SO FAR AS THE AGENT ORANGE SITUATION, GOVERNOR DUKEMEJIAN OF CALIFORNIA VETOED ASSEMBLY TOM HAYDEN'S BILL TO ALLOW TESTING AND MEDICAL CARE FOR MILITARY PERSONNEL LIVING IN CALIFORNIA. IF THE MILITARY ARE EXCLUDED FROM THIS, THEN WHAT CHANCE DO WE CIVILIAN VIETNAM VETERANS HAVE OF GETTING TREATMENT FOR AGENT ORANGE PROBLEMS OR POST TRAUMATIC STRESS PROBLEMS. FOLLOW THE BOUNCING BALL, GENTLEMEN, BECAUSE IT IS GOING TO BE IN YOUR COURT ANY MINUTE.

WE WOMEN CIVILIAN VIETNAM VETERANS, WHO SERVED WITH THE U.S.O., AMERICAN RED CROSS AND U.S. ARMY SPECIAL SERVICES, ARE YOUR CONSTITUENTS. WE PUT YOU IN OFFICE. IF YOU FAIL TO HEAR OUR CRY NOW, DON'T EXPECT US TO DO THE SAME FOR YOU AGAIN. EVEN THOUGH WE MAY BE A SMALL MINORITY, DON'T UNDERESTIMATE OUR POWER. REMEMBER, IT TAKES A FEW TO INFLUENCE THE MANY. ALWAYS HAS AND ALWAYS WILL BE TRUE.

GRANTED THERE IS A LONG ROAD TO TRAVEL ON THIS ISSUE. ATTENTION MUST BE PAID TO OUR NEEDS. IGNORING THE PROBLEM WILL NOT MAKE IT GO AWAY. THROUGHOUT AMERICAN HISTORY WOMEN HAVE SERVED IN QUIET ISOLATION. BUT THE TIDE IS CHANGING. YOU ARE DEALING WITH A NEW GENERATION OF WOMEN, WOMEN WHO FIND IT NECESSARY TO SPEAK UP AND OUT AND WITH OBVIOUS RESULTS. THE VOICE OF WOMANKIND IS EMBARKING ON A NEW ERA. TIMES ARE CHANGING. WE MUST BE RECOGNIZED AND IT IS UP TO US TO FORM AN ALLIANCE WITH YOU TO MAKE THAT CHANGE POSSIBLE.

THANK YOU.

Maureen Nerli

MAUREEN E. NERLI
2460 Poppy Drive
Burlingame, CA 94010
(415) 347-2007

SERVED AS ASSOCIATE DIRECTOR OF THE TAN SON NHUT U.S.O IN VIETNAM -- 1969 to 1970
SERVED AS ASSOCIATE DIRECTOR OF THE UTAPAO U.S.O. IN THAILAND -- 1971 to 1972
SERVED AS DIRECTOR OF U.S. ARMY SPECIAL SERVICE CLUBS IN KOREA ---1972 to 1974
SERVED AS DIRECTOR OF U.S. ARMY SPECIAL SERVICE CLUB AT FORT ORD, CALIFORNIA ---1974 to 1976

ILLIAM S. COHEN
MAINE

United States Senate
WASHINGTON, D.C. 20510

April 11, 1984

The Honorable Alan K. Simpson
Chairman
Committee on Veterans Affairs
SR-414
Washington, D.C. 20510

Dear Al:

I am writing to thank you and the entire Committee membership for providing Senator Mitchell and myself with an opportunity to use today's legislative hearing on Veterans Health Care to focus on the concerns that rural veterans in Maine have about the availability of authorized Veterans Administration (VA) health-care services.

On March 29, in preparation for today's hearing, Senator Mitchell wrote to Harry Walters and outlined several questions that we would like to have answered by the VA regarding this issue. It is my hope that the Veterans Administration will address these questions in its testimony today so that Senator Mitchell and I may proceed with our plans to offer legislation that will begin to address Maine veterans' concerns during the Committee markup of a health bill on May 2.

The legislation that we are proposing would accomplish two things. As Senator Mitchell's bill S.523 would do, our bill would provide for an experimental rural health-care program for eligible veterans in Aroostook County in northern Maine.

In this regard, I am pleased to see that the Administration's Fiscal Year 1985 VA budget includes $105,000 to determine the cost-effectiveness of providing health care for rural veterans in several rural health centers in Maine. This project has received initial approval from both the VA medical center at Togus, Maine and the VA in Washington and it is our intention to see that Aroostook County veterans can participate in that or some other experimental program this year.

Our bill will also require the VA to develop statistics that would allow the Committee to determine the true extent of the problem that the VA has in providing adaquate health-care services to eligible veterans who live in other rural areas of the country.

During hearings on S.523 last July, Senator Mitchell amply demonstrated that eligible rural veterans in Maine use VA health-care services much less frequently than do veterans who live short distances from Togus. In Maine, statistics indicate that when rural

The Honorable Alan K. Simpson
April 11, 1984
Page two

veterans finally do come to the VA for medical assistance their problems are usually more severe than are those of other veterans. The result of this inequitable situation seems to be extended stays at Togus, with higher costs for the VA health-care system.

Because the VA has been unable to provide comparable statistics for rural veterans in other areas of the country, Senator Mitchell and I believe that it is time for the VA to develop those statistics. We also believe that it is time for the VA to focus upon cost-effective health-care alternatives for rural veterans in Maine and in other portions of the country.

The establishment of an experimental health-care project in northern Maine this year would be an important first step in this process.

Again, thank you for your assistance in allowing me to explore these important alternatives with the Committee and with the VA.

With warm regards, I am

Sincerely,

Bill

William S. Cohen
United States Senator

WSC/jhk

Association of Halfway House
Alcoholism Programs of No. America, Inc.
Office: 786 East Seventh Street, St. Paul, MN 55106 612-771-0933

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April 3, 1984

The Honorable Alan Simpson, Senator
Chairman Veterans Foreign Affairs Committee
Senate Building, Suite 414
Washington, D. C. 20510

Dear Senator Simpson:

The Association of Halfway House Alcoholism Programs supports legislation to make permanent the VA Halfway House Contract Program. AHHAP recovery facilities presently under contract believe the program is of benefit to veterans served and to community programs.

Concerns expressed by member homes are shared below:

1) That local VA hospitals accept State Facility Licensing and State Program Certification as quality assurance. Some local hospitals require their own inspection visits prior to contract approval.

2) That provision be made in the VA contract law that allows local VA hospitals to contract for community Social Detoxification services when adequate detoxification service is unavailable in VA hospitals.

3) That authorized payment limit be kept at ninety days. Some veterans need ninety days to enter employment, stabilize in recovery and find independent housing. The best approach is a sixty day plan with a possible thirty day extension.

AHHAP appreciates the efforts made by the Senate Finance Committee. The Halfway House/VA Contract Project initiated by the Committee in 1979 was an inspired effort.

Please contact me at (213) 450-5123 (CLARE Foundation) if I can be of further assistance.

Sincerely,

Ken Schonlau
Ken Schonlau
President

cc: Senator Alan Cranston

KS:mds

Medical Center

Seventh Street and Indian
School Road
Phoenix, AZ 85012

Veterans
Administration

May 3, 1984

In Reply Refer To: 644/116A

Alan K. Simpson, Chairman
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Senator Simpson:

This is in response to the question you addressed to me in your letter of April 25, 1984, asking "What experiences have you had, both positive and negative, regarding Veterans' Administration Central Office units or services which address specific mental health disorders?" You indicated that my reply should include, but not be limited to my experiences in relation to treating Post-Traumatic Stress Disorder.

I was first appointed as a Chief of Psychiatry at a VA Medical Center in 1978, and have served in that capacity at three facilities, presently at Phoenix, Arizona. On numerous occasions it has been necessary to confer with staff of the Mental Health and Behavioral Sciences Service regarding professional issues. Some of these discussions have been at conferences arranged by the Central Office, some have been in individual meetings at the Central Office when I have been there on official business, but most have been by telephone.

The Alcoholism Treatment Units are administratively part of the Chief, Psychiatry responsibilities, and there is an administrative unit in the Mental Health Service in C.O. which provides guidance to the field operations. They have frequent direct contact with the Coordinators of the alcoholism units in the medical centers, and issue detailed program guidelines for program operations, direct such activities as surveys and statistical reporting, and serve as coordinating contact points for other matters. A recent example of the latter is a downgrading of alcoholism rehabilitation counselors mandated by the Office of Personnel Management which played havoc with operations in the field, and which the VA Central Office alcoholism program staff assisted me and my Alcoholism Program Coordinator to address. In most instances, my experiences with that Central Office unit have been positive.

The specialized treatment units for Vietnam veterans with Post-Traumatic Stress Disorder are likewise operated as part of the Psychiatry Service at the medical centers, since they utilize inpatient psychiatric beds and, sometimes, part of the Mental Hygiene Clinic. Accordingly, the Chief, Psychiatry Service is administratively responsible. After I established such a unit in Florida in 1981, I maintained close communication with staff of the few other such units as they were established. We shared experiences and developed rather similar patterns of operation. Except for one Director and one psychiatrist in the Mental Health Service in Central Office, I found little clinical familiarity with this disorder, and could identify no official recognition, support, or policy position on such units. On several occasions I was able to elicit some interest in clinical and administrative issues which I confronted regarding my unit, but no really useful assistance. I am now in the process of establishing a PTSD unit at Phoenix, and would find it helpful if the Central Office were to establish a single point of contact, especially in regard to issues of staffing, resources, the DRG impact on budgeting, professional education, program policies, and research.

I am also a member of the Advisory Committee on Readjustment Problems of Vietnam Veterans to the Administrator of Veterans Affairs. Some of the issues I have raised in that capacity have not been responded to with the knowledge and concern which I associate with Central Office staff having a specific assigned program responsibility.

Sincerely,

Arthur L. Arnold MD

ARTHUR L. ARNOLD, M.D.
Chief, Psychiatry Service

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, D.C. 20510

March 13, 1984

Dr. Donald L. Custis
Chief Medical Director
Veterans' Administration
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Don,

Enclosed is a February 13, 1984, letter to me from Mr. Joseph L. Collins, Executive Director, California Association of Alcoholic Recovery Homes (C.A.A.R.H.), by which he forwarded the results of a survey conducted by C.A.A.R.H. on the experience of its member programs under the pilot program authorized by section 620A of title 38, United States Code. Under this program, the Veterans' Administration contracts with halfway houses and other community-based facilities for the treatment and rehabilitation of certain veterans with alcohol or drug disabilities.

As the author of the legislation establishing the pilot program, I continue to have a very strong interest in this program and have introduced legislation (section 5 of S. 2269) to make this contract authority permanent. Thus, I am particularly interested in the views of C.A.A.R.H. and the results of the association's survey and would appreciate it if you would review both the letter and the results of the survey and give me your views on both by March 31, 1984, so that I might have the opportunity to review your views prior to the Committee's April 4 hearing, at which S. 2269 will be considered. In addition, I would appreciate learning, at the same time, about the agency's views and actions with respect to the evaluation of the pilot program (a portion is enclosed as addendum IV to the C.A.A.R.H. survey) submitted to the VA by National Capitol Systems, Inc., and Associated Research Analysis Corporation.

Thank you for your continuing cooperation.

With warm regards,

Cordially,

Alan Cranston
Ranking Minority Member

Enclosure

Department of Medicine and Surgery **Washington D.C. 20420**

Veterans Administration

APR 10 1984

(116A3)
In Reply Refer To:

Honorable Alan Cranston
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Senator Cranston:

I have the pleasure of responding to your letter of March 13, 1984, in which you asked for my views on your letter from Mr. Joseph L. Collins, Executive Director of the California Association of Alcoholic Recovery Homes (C.A.A.R.H.), in which he reported on the results of a survey of C.A.A.R.H.'s experience with VA contracts during FY 1983.

The results of the C.A.A.R.H. survey are quite encouraging, and are parallel to the VA pilot contract program's reports of experience across the country.

In the Veterans Administration's earlier testimony in support of the proposed pilot contract program, we had described there were complex problems encountered in discharge planning and the effective return into constructive community membership, for six to eight percent of admissions to the VA's alcohol or drug dependence treatment programs. These patients had histories of repeated entries to both VA and other treatment programs. They often lacked competitive job skills, and demonstrated little in the way of self-help skills. They were at high risk for early relapse after the medical and psychological crises which required their hospitalizations were treated and controlled.

The Veterans Administration's medical centers have focused on this recovery-resistant cohort of veterans in utilizing the contract authority of Section 620A of Title 38, United States Code. Since the patients placed into the contracted programs were particularly relapse-prone, the C.A.A.R.H. survey's findings of significant improvements are especially laudable. Their report that two out of three admissions completed the contracted program, that 84 percent of those completing the contracted program were employed or otherwise self-sufficient, and that 69 percent of those who completed the contract program were maintaining sobriety, are highly encouraging measures of treatment effectiveness.

The data on cost benefits of the California-based programs are persuasive; the moderate per diem cost of contracted residential rehabilitation provides a near-ideal supplement to the VA medical center-provided acute care phase of treatment. The high percentage of contract program completions reflect an accuracy in selection of patients for further residential care.

Honorable Alan Cranston

I am providing, by enclosure, my responses to the six recommendations with which the C.A.A.R.H. survey was concluded.

The Administrator is forwarding to your office the report of evaluation of the pilot program submitted to the VA by National Capitol Systems, Inc., and Associated Research Analysis Corporation. That report provides a number of evidences of significant treatment benefits and of cost effectiveness realized through the selective use of contract linkages with non-VA community-based programs. We believe the findings provide a firm basis for requesting that the pilot contract authority provided by section 620A of Title 38 of United States Code, be made permanent.

Sincerely,

DONALD L. CUSTIS, M.D.
Chief Medical Director

Enclosure

Comments on the Six Recommendations with which the California Association of Alocholic Recovery Homes (C.A.A.R.H.) Survey was concluded.

Reference Recommendation I: The C.A.A.R.H. study provides strong support for your proposal to make this contract authority permanent. Our recently completed nationwide study is equally supportive. I support the recommendation as you have expressed it in your bill.

Reference Recommendation II: The VA's FY 1983 experience with such contract programs in California involved the placements of 782 veterans into 43 different non-VA contracted community-based programs. In our consideration of proposed contracts, we review the data on actual costs for a program's operation, and attempt to meet the actual cost experience of the proposed contractee. In some contrast to the C.A.A.R.H. study's report that 15 programs with VA contracts averaged $18.85 per diem, the average per diem paid during FY 1983 to the 43 California programs was $27.73 per residency day, 47 percent higher than the average reported by C.A.A.R.H. for the smaller group of programs. The contracted per diems which are developed with community-based programs show considerable range in amounts, reflective of differences in staffing and other factors. We believe our record of careful management of resources in today's austere environment contributes a great deal to the success of both program operations and cost containment.

Reference Recommendation III: We believe there is not sufficient justification for the proposal of unlimited budget support for individual stays in contract programs. The Veterans Administration is striving for ever shortening lengths of stay in inpatient units, to encourage earliest possible return to community roles and self-help activities. We should avoid any budgetary disincentives for earliest possible discharges from the community-based residential programs as well.

Our guidelines for such contracts call for reimbursement of 60 days of care, and this may be extended up to 90 days of residential treatment in selected cases. This provides a significant budget augmentation for the community programs. The average length of stay reported in the C.A.A.R.H. survey of programs was 89 days; even considering the one-third of admissions who did not complete the contract programs, there were 67 percent who did complete the planned course of rehabilitation. There was no indication that any who left prematurely were discharged because of any limitation in VA budget supplements to the contract programs. We will, of course, continue to follow our cost experiences with the contract programs, but at present there does not appear to be justification to so radically modify or broaden the policy on anticipated reimbursement.

17

Reference Recommendation IV: I do not support the proposal for selective limitation of acute care for hospitalized veterans when the disorder is alcohol-related. There are numerous problems. The direct complications of chronic alcoholism are often associated as reasons for hospitalization, i.e. liver cirrhosis, organic brain syndromes, auto accidents, pancreatitis, and other such disorders. The denial of hospitalization to such veterans, on the basis of limited days of treatment per year, would risk aggravating their potentially fatal disorders. Veterans coming to the VA for acute care of alcohol dependence and the related system diseases need comprehensive biomedical and psychosocial assessments to identify the medical and psychiatric disorders needing early treatment as well.

Another problem relates to whether hospitalization days (against an annual allowance) would include hospitalizations after which the diagnosis of alcoholism was recorded on the chart's front sheet as an associated diagnosis, rather than the principal diagnosis. The condition is no less present, and treatment for that condition was provided.

Regardless of the question of merit, the proposal to limit VA hospital days per year to veterans, by restricting on the basis of diagnosis alone, would be quite difficult to implement. It would require that veterans arriving at the VA medical center for acute care of alcohol or drug dependence, and who are assessed as needing hospitalization, would be placed on an administrative hold prior to their arrival on the ward while the question of total days of inpatient treatment for the diagnosis of alcohol or drug dependence during the preceding 365 days, was researched. It might be possible to develop and maintain a running log on all patients discharged from that medical center with the principal diagnosis of alcohol or drug dependence, and a running total of days of inpatient care for these diseases. However, in the absence of a VA-wide computer search capability which would collect and provide the patient-specific totals representing a search of all VA medical centers by patient name, dates of admission and discharge, and keyed to the principle diagnosis, such a systematized type of approach to denying direct services to veterans anticipates the state of the art.

In summary, I do not support the recommendation because it would tend to create an exclusionary environment which would encourage both clinical staff and patients to deny the presence of alcoholism by avoiding the diagnosis, would tend to contribute important delays in needed treatment for many veterans, and would aggravate a stereotype problem we have been attempting to eliminate.

Reference Recommendation V: I do not support this recommendation because it would diminish VA oversight activities which provide quality assurance to the contract program. Currently, the VA medical center clinical staff assesses such referrals prior to contract placements, for correctness of diagnosis, and for level of care needed at a particular point in the veteran's treatment, and they initiate plans for the continuing followup of the veteran's rehabilitation experience by VA-provided aftercare contacts. The proposal would eliminate this important triage function. Implementation of such a proposal could require a massive growth of budget, for such an open-ended authorization of admissions. The current authority responds well to the VA's need for a cost-effective option for veterans who need transitional residential support after acute care. Linkages between VA medical centers and contracted community-based programs, as currently exercised, provide those needed supports. The program is growing at upwards of ten percent per annum in volume of services.

Reference Recommendation VI: We continue to explore all possible areas of potential programmatic benefit and cost containment. We have studied the important modality of non-hospital, social detoxification and have strong linkages with such programs in a number of locations. We admit a sizable number of veterans directly to ambulatory care to obviate hospitalization, and we provide non-hospital detoxification for many of these cases. During FY 1983, there were 11,643 direct admissions to ambulatory care provided by the VA's alcoholism treatment programs, a 9.6% increase over FY 1982. During FY 1983, there were 3,615 direct admissions to ambulatory care provided by the VA's drug dependence treatment programs, a 5.2% increase over FY 1982. However, many veterans who present directly at the VA medical centers requesting acute care, require hospitalization and a comprehensive medical examination, to include biomedical and psychosocial assessments, for development of an optimal treatment plan. For each veteran, consideration is made in the treatment plan for placement of the veteran in the appropriate level of care. We will continue to monitor VA treatment programs for potential improvements in cost containment parameters as well.

[illegible]

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, D.C. 20510

April 13, 1984

Mr. Joe Collins
Executive Director
California Association of
Alcoholic Recovery Homes
2146 West Adams Boulevard
Los Angeles, California 90018

Dear Mr. Collins,

I am writing in follow-up to our earlier correspondence and to the Committee's April 11 hearing on various legislative proposals.

Enclosed is a copy of the letter I received from Dr. Donald Custis, the Veterans' Administration's Chief Medical Director, in reply to my March 13, 1984, letter to him which, as you know, forwarded a copy of your letter (and survey). I am very pleased with the positive tone and content of Dr. Custis' letter and believe that his response is a good sign for the prospects of the various bills that would make the VA's pilot program a permanent authority.

With reference to the Committee's hearing, I would appreciate your written views, as soon as possible, on the following questions concerning S. 2514 (a copy of which is enclosed):

1. Section 3 of S. 2514, as part of amending current law to make the VA's pilot program a permanent authority, would provide that the "maximum period for one [halfway house] treatment episode ... shall be limited to sixty days." Would the California Association of Alcoholic Recovery Homes (CAARH) support such a limit?

2. Section 3 would further require the VA to issue regulations which would, among other things, "establish maximum periods of treatment for alcohol or drug dependence or abuse disabilities" which would have to be "consistent with average periods of such treatment and rehabilitation" in non-VA programs. The specific steps of treatment that would have to be addressed would include:

-- detoxification;

-- acute inpatient care and treatment;

-- additional extended care and treatment in certain cases; and

-- outpatient care and treatment.

Would CAARH support a requirement that the VA establish such maximum periods?

[If yes] What, in your opinion, would be appropriate maximum periods for each of the specified stages?

Thank you for your testimony for the Committee's hearing and for the fine work that you and the members of CAARH are doing. I look forward to your responses to the above questions.

With best wishes,

Sincerely,

Alan Cranston
Ranking Minority Member

Enclosures

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"A half-way house for men on the way back"

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ADMINISTRATION DIRECTOR
KENNETH R. LEMON

April 17, 1984

The Honorable Senator Alan Cranston
Ranking Minority Member of the
Veteran's Affairs Panel
Washington D.C.

Dear Senator Cranston:

I am writing you in regards to the Veterans Administration Health Care Programs Improvement Act of 1984.

Senator, I have been involved in this program for the past two years. I have a contract with the Fort Lyon V.A. Medical Center in Fort Lyon, Colorado. In the past two years I have processed seventy-two (72) veterans through our Reintegration Program (half-way house). This program has been very successful. We help the veterans find employment, stay sober and/or straight, and get their lives straightened out. We have had about 75% of the veterans who are referred here complete the program. I am enclosing a set of our rules, so you can see that we do have a good program. If there is any information I can furnish you from our program that will help you in your endeavor to make this law permanent. Our Reintegration program consists of a minimum of three (3) hours counseling per week, employment counseling, this is helping the client with job resumes, on the job training programs, filling out applications for employment, personal appearance, and financial responsibility.

If there is any way I can be of futher service to you please feel free to call upon me. This law is very important to the veterans as well as Alcohol/Drug Treatment Programs. I remain,

Sincerely yours,

Kenneth R. Lemon

Kenneth R. Lemon, CAC,
Administration Director, Sunrise, Inc.
523 Main, Larned, Kansas 67550
(316) 285-3462

SUNRISE, INC., CRITERIA OF ADMISSION

YOU ARE HERE BECAUSE YOU HAVE A PROBLEM WITH ALCOHOL/OR DRUGS. WE HOPE YOU HAVE COME TO SUNRISE IN ORDER TO DO SOMETHING ABOUT YOUR PROBLEM. TO MAKE SOME CHANGES IN YOUR LIFE STYLE. SO THAT YOU WILL NOT RELY ON ALCOHOL/OR DRUGS AS YOUR PROBLEM SOLVER.

THE PURPOSE OF THIS PROGRAM, IS NOT JUST TO GIVE YOU A ROOF OVER YOUR HEAD, AND THREE MEALS A DAY. OUR PURPOSE IS TO ASSIST YOU IN REGARDS TO YOUR PROBLEMS. TO ASSIST YOU TO CHANGE SOME ATTITUDES, TO RECOGNIZE YOUR FEELINGS, AND HOW TO FACE EVERY DAY LIVING WITH OUT THE USE OF ALCOHOL/OR DRUGS. WE ARE NOT HERE TO DO IT FOR YOU, BUT TO ASSIST YOU AND TO OFFER SOME ALTERNATIVES IN YOUR EVERYDAY LIVING. IT IS GOING TO TAKE SOME WORK ON YOUR PART IN ORDER TO LIVE A SOBER LIFE. WE HOPE THAT YOU WILL CHOOSE THIS PATHWAY OF LIFE. IF YOU DONT WANT SOBRIETY, AND YOU DONT WANT WHAT WE HAVE TO OFFER PLEASE DONT WASTE OUR TIME AND YOURS BY PRETENDING. THERE ARE MANY OTHERS OUT THERE WHO WOULD LIKE OUR HELP.

YOU WILL BE GIVEN A SET OF RULES AND REGULATIONS THAT YOU WILL BE REQUIRED TO LIVE BY WHILE YOU ARE HERE. READ THEM CAREFULLY AND BE SURE YOU UNDERSTAND THEM, BECAUSE THESE RULES AND REGULATIONS WILL BE WHAT YOU LIVE BY WHILE AT SUNRISE. YOU WILL BE ASKED TO SIGN A RELEASE, ON THIS RELEASE IT STATES THAT YOU HAVE BEEN GIVEN A SET OF RULES AND REGULATIONS AND THAT YOU UNDERSTAND THEM.

YOU HAVE A PROGRAM TO COMPLY WITH AND EVERYONE IS EXPECTED TO WORK THIS PROGRAM, WHILE YOU ARE AT SUNRISE, REGARDLESS OF YOUR LENGTH OF STAY.

ANY ONE WHO DOES NOT COMPLY WILL BE DISCHARGED. THOSE OF YOU WHO ARE ON PROBATION OR PAROLE WILL BE RETURNED TO YOUR PROBATION OR PAROLE OFFICER, AS NOT COMPLYING WITH THE PROGRAM AND MOST OF YOU ARE HERE AS CONDITION OF PROBATION OR PAROLE AND WILL PROBABLY MEAN RETURNING TO JAIL OR PRISON. WE SINCERELY HOPE THIS DOESNT HAPPEN, BUT WE WANT YOU TO BE AWARE THAT THIS CAN HAPPEN.

WE WANT YOUR STAY AT SUNRISE TO BE A PLEASENT ONE AND A SUCCESSFUL ONE. WE ARE HERE TO HELP YOU ANYWAY WE CAN WITHIN THE CONFINES OF OUR PROGRAM.

Kenneth K. Lemus
KENNETH LEMUS, CAC
ADMINISTRATION DIRECTOR
SUNRISE, INC.

SUNRISE, INC., RULES AND REGULATIONS
1983

1. POSSESSION OF ALCOHOLIC BEVERAGES, MARIJUANA, OR NON-PRESCRIBED CONTROL OR ILLEGAL DRUGS ARE FORBIDDEN. PERSONS VIOLATING THIS RULE WILL BE EVICTED AND BARRED FROM THE HOUSE AND IT'S SERVICES FOR ONE YEAR.

2. ANY RESIDENT WHO CONSUMES ALCOHOL OR USES DRUGS WILL BE EVICTED IMMEDIATELY, AND WILL NOT BE ELIGIBLE FOR READMISSION FOR 30 DAYS. IF THE RESIDENT IS IN DEBT TO THE HOUSE FOR RENT OR SERVICES, THIS DEBT MUST BE PAID PRIOR TO READMISSION.

3. THE RESIDENT MUST INFORM THE COUNSELOR ASSIGNED OF ALL MEDICATION IN HIS POSSESSION OR BROUGHT INTO THE HOUSE DURING RESIDENCY. ALL MEDICATION MUST BE CHECKED INTO THE OFFICE AND STORED IN A LOCKED CABINET. THIS MEDICATION WILL BE GIVEN TO THE CLIENT BY AN OFFICE STAFF PERSON, AND RECORDED IN A MEDICAL CHART SHEET, STATING THE AMOUNT AND TIME GIVEN, AND A STAFF PERSON SHALL INITIAL CHART. THE CLIENT REMAINS RESPONSIBLE TO COME TO THE OFFICE AND TAKE HIS MEDICATION AS DIRECTED BY HIS DOCTOR.

4. ALL RESIDENTS ARE ON PROBATION FOR THIRTY DAYS FOLLOWING ACCEPTANCE INTO THE HOUSE. PERSONS WHO RECEIVE THIRD PARTY PAYMENTS (VR, GA, OR SRS) REMAIN ON PROBATION UNTIL BECOMING INDEPENDENT OF THE THIRD PARTY SUPPORT. RESIDENTS PAROLED TO THE HOUSE BY STATE OR COUNTY OFFICIALS, COURT OA LAW OFFICIALS, WILL REMAIN ON PROBATION UNTIL WRITTEN RELEASE FROM THE AGENCY HAS BEEN RECEIVED. ALL PERSONS LIVING AT SUNRISE WHO ARE ON PROBATION OR PAROLE SHALL HAVE A SPECIAL CONDITION ON THEIR PROBATION OR PAROLE TO INCORPORATE SUNRISE HOUSE RULES INTO THEIR PROBATION OR PAROLE.

5. ALL RESIDENTS ARE REQUIRED TO BE AT THE HOUSE BY MIDNIGHT, THIS IS EVERY NIGHT OF THE WEEK. ALL RESIDENTS ARE TO NOTIFY THE DIRECTOR OR HIS DESIGNEE WHEN THEY PLAN ON BEING AWAY FROM THE HOUSE OVERNIGHT OR LONGER, AS TO WHERE THEY CAN BE LOCATED IN CASE OF EMERGENCY. PASSES ARE AVAILABLE IN THE OFFICE FOR THESE OCCASIONS, AND MUST BE APPROVED BY YOUR COUNSELOR AND/OR ADMINISTRATION DIRECTOR. ALL COUNSELING SESSIONS, AA MEETING REQUIREMENTS MUST HAVE BEEN MET BEFORE YOU ARE ELIGIBLE FOR A PASS. PROBATION AND PAROLE PERSONS MUST HAVE AN OK FROM THEIR PROBATION AND/OR PAROLE OFFICER;

6. ALL RESIDENTS ARE REQUIRED TO ATTEND THE WEEKLY AA MEETING AT THE HOUSE. RESIDENTS MUST ALSO ATTEND AT LEAST ONE AA MEETING EACH WEEK AWAY FROM THE HOUSE. THOSE CLIENTS WHO WORK NIGHTS MUST MAKE ARRANGEMENTS WITH THEIR COUNSELOR TO MAKE UP MEETINGS MISSED. IT IS THE RESPONSIBILITY OF THE CLIENT TO REPORT TO HIS COUNSELOR ANY OUTSIDE MEETING ATTENDED. ALL CLIENTS ARE REQUIRED TO ATTEND THE HOUSE GOVERNMENT AND GROUP COUNSELING SESSIONS. EACH CLIENT WILL BE GIVEN A COPY OF A SCHEDULE OF ALL THE ABOVE MEETINGS.

7. EXPERIENCE INDICATES THE DANGER AND INADVISABILITY OF NEW MEMBERS MAKING "TWELVE STEP CALLS". RESIDENTS WILL MAKE TWELVE STEP CALLS IN PAIRS, ONE OF WHOM MUST HAVE AT LEAST SIX MONTHS SOBRIETY OR DRUG FREE. RESIDENTS MAKING TWELVE STEP CALLS ON FEMALE ALCOHOLIC OR DRUG ADDICTED PERSON MUST HAVE SIX MONTHS SOBRIETY OR DRUG FREE AND BE ACCOMPAINED BY A FEMALE RECOVERING ALCOHOLIC OR DRUG ADDICTED PERSON.

8. RESIDENTS CAPABLE OF WORKING ARE REQUIRED TO SEEK EMPLOYMENT, AND THE HOUSE WILL GIVE ASSISTANCE IN FINDING EMPLOYMENT AS SOON AS POSSIBLE. NO CLIENT WILL GO TO WORK UNTIL ALL PAPER WORK HAS BEEN COMPLETED. NIGHT JOBS ARE DISCOURAGED AND ARE NOT PERMITTED IF THEY INTERFERE WITH YOUR RECOVERY PROGRAM. ALL RESIDENTS MUST DISCUSS NIGHT EMPLOYMENT WITH THE DIRECTOR BEFORE ACCEPTING A NIGHT JOB.

9. ANY FINANCIAL OBLIGATION TO THE HOUSE MUST TAKE PRECEDENCE OVER ALL OTHER INDEBTEDNESS. ROOM AND BOARD IS DUE IN ADVANCE UNLESS OTHER ARRANGEMENTS ARE AGREED UPON BETWEEN THE CLIENT AND ADMINISTRATION DIRECTOR.

10. FOR HEALTH AND ECONOMY REASONS MEAL SCHEDULES AND KITCHEN REGULATIONS MUST BE OBSERVED. NO ONE, EXCEPT AUTHORIZED PERSONS, ARE ALLOWED IN THE KITCHEN AREA. THE MEAL SCHEDULE IS POSTED ON THE KITCHEN SERVING WINDOW. WHEN WORK HOURS PREVENT MEETING MEAL SCHEDULES, THE COOK WILL BE NOTIFIED BY THE CLIENT, AND FOOD WILL BE SET ASIDE FOR THE CLIENT. IF CLIENT IS WORKING ON A JOB THAT REQUIRES TAKING A LUNCH, THE CLIENT MUST NOTIFY THE COOKS THAT HE WILL NEED A LUNCH.

    SNACK FOOD ITEMS MAY BE PURCHASED, MARKED AND STORED IN SNACK ROOM ON 2ND, AND 3RD. FLOOR. THSES SNACK FOODS MUST BE EATEN IN THE SNACK ROOMS. NO FOOD ITEMS WILL BE STORED IN INDIVIDUAL ROOMS. THIS IS DUE TO HEALTH REGULATIONS. THE HOUSE DOES NOT ASSUME ANY RESPONSIBILITY OR LIABILITY FOR THE SAFEKEEPING OF THESE ITEMS. THERE WILL BE NO COOKING IN ROOMS.

    DISSATISFACTION WITH ANY PHASE OF FOOD SERVICE MUST BE DISCUSSED WITH THE ADMINISTRATION DIRECTOR ONLY.

11. HOUSEKEEPING IS THE RESPONSIBILITY OF EACH INDIVIDUAL AND ALL RESIDENTS COLLECTIVELY. EACH RESIDENT MUST MAKE HIS BED DAILY, STORE PERSONAL BELONGINGS, HANG AND FOLD CLOTHING NEATLY.

    THE WASH BASINS, BATH TUBS AND SHOWERS MUST BE CLEANED THOROUGHLY AFTER EACH USE.

    THE ADMINISTRATION DIRECTOR OR HIS DESIGNEE IS RESPONSIBLE FOR ASSIGNING CLEANING DUTIES. ALL PERSONS NOT WORKING WILL BE ASSIGNED TO CLEANING DUTIES UNTIL SUCH TIME AS THEY ARE EMPLOYED. THIS MUST BE DONE IN ORDER TO MEET HEALTH AND ENVIORNMENT AGENCY RULES.

12. BATHROBES, UNDERSHIRTS AND BATHING SUITS ARE NOT APPROPRIATE IN THE DINING AND LOUNGING AREAS. SLIPPERS OR SOME TYPE OF FOOT WEAR ARE NECESSARY OUTSIDE OF INDIVIDUAL ROOMS. SHIRT, PANTS, AND SHOES ARE TO BE WORN IN THE DINING ROOM FAILURE TO BE PROPERLY DRESSED WILL MEAN THAT YOU WILL NOT BE SERVED YOUR MEAL.

13. PERSONAL HYGIENE AND CLEANLINESS ARE EVIDENCE OF PRIDE AND SELF-ESTEEM. FREQUENT BATHING WITH NEAT HAIR AND/OR BEARDS IS REQUIRED OF ALL RESIDENTS.

14. LAUNDRY FACILITIES ARE PROVIDED BY THE HOUSE. BED LINENS WILL BE FURNISHED BY THE HOUSE. THEY WILL BE WASHED ONCE A WEEK BY THE CLIENT. THESE FACILITIES WILL BE FURNISHED AS LONG AS THE CLIENTS TAKE CARE OF THEM. ANY CLIENT WHO MISTREATS THE WASHER OR DRYER BY NOT KEEPING THEM PROPERLY CLEANED WILL BE BARRED FROM THE USE OF THIS FACILITY.

15. RESIDENTS ARE ENCOURAGED TO AFFILIATE AND ATTEND THE CHURCH OF THEIR CHOICE. MOST DENOMINATIONS ARE REPRESENTED HERE.

16. GUESTS ARE ALLOWED IN THE VISITING ROOM ON FIRST FLOOR ONLY. THERE WILL BE NO FEMALE GUESTS ABOVE THE FIRST FLOOR EXCEPT TO ATTEND AA OR NA MEETINGS.

17. TV'S, RADIO, AND STERIOS ARE TO BE TURNED OFF DURING ALL MEETINGS. TV'S RADIOS, STERIOS WILL BE TURNED DOWN AND KEPT AT A MINIMUM NOISE LEVEL. THOSE GUILTY OF LOUD PLAYING OF THESE INSTRUMENTS WILL HAVE THEM REMOVED FROM THEIR ROOM AND THEY WILL BE STORED UNTIL CLIENT LEAVES THE HOUSE.

18. SPACE FOR PARKING IS LIMITED. RESIDENTS CARS MUST BE PARKED ON THE NORTH SIDE OF THE BUILDING. THERE ARE 13 PARKING SPACES AND IF EVERY ONE WILL PARK PROPERLY THERE IS PLENTY OF ROOM. THE HOUSE WILL NOT ASSUME ANY RESPONSIBILITY FOR CLIENT'S CARS OR CONTENTS.

19. THE ADMINISTRATION DIRECTOR OR HIS DESIGNEE, ACCOMPAINED BY ANOTHER PERSON, HAS THE AUTHORITY AND RESPONSIBILITY TO THOROUGHLY SEARCH THE PERSONAL EFFECTS OF ANY RESIDENT AT ANY TIME, IF EVIDENCE IS AVAILABLE THAT DRUGS, ALCOHOL, OR ANY OTHER REASON THAT THIS SEARCH IS NEEDED, IF ANY UNLAWFUL COUNTRABAND IS FOUND, EVICTION IS MANDATORY.

20. STATE GUIDE LINES FOR TREATMENT FACILITIES PROHIBIT DATING AND/OR SEXUAL CONDUCT BETWEEN STAFF AND CLIENT AND/OR CLIENT AND STAFF.

21. THERE SHALL BE NO PHYSICAL OR VERBAL ABUSE OF A CLIENT BY THE STAFF OR FROM CLIENT TO STAFF.

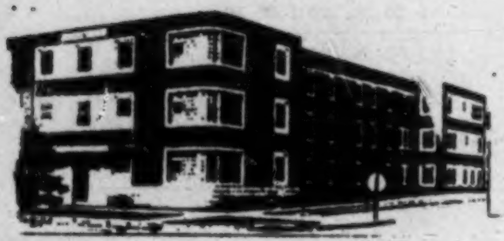
22. THERE SHALL BE NO NON-THERAPEUTIC DEMEANING VERBAL ABUSE BETWEEN STAFF AND CLIENT. THE ILLEGAL POSSESSION, USE, OR SALE OF ALL DRUGS AT ANY TIME AND THE ABUSE OF ALCOHOL IS FORBIDDEN.

23. THERE SHALL BE NO FIRE ARMS OR ILLEGAL KNIVES OR WEAPONS BROUGHT INTO THE HOUSE BY CLIENTS.

24. IT SHALL BE THE POLICY OF SUNRISE, INC., TO INFORM THE CLIENTS OF VISITATION OF PRESS, RADIO OR ANY OTHER MEDIA AND GIVE THEM THE OPTION TO BE PRESENT OR ABSENT DURING SUCH VISITATIONS.

25. CLIENTS WHO ARE ADMITTED TO SUNRISE WITHOUT RENT IN ADVANCE MAY KEEP THE MONIES THAT THEY EARNED ON THEIR FIRST "SPOT LABOR JOB". AFTER THE FIRST "SPOT LABOR JOB", ONE-HALF OF ALL SPOT LABOR MONEY SHALL BE APPLIED TO THEIR RENT ACCOUNT. THERE WILL BE NO EXCEPTION UNLESS APPROVED BY THE ADMINISTRATION DIRECTOR OR HIS DESIGNEE.

ANY RESIDENT UNABLE OR UNWILLING TO LIVE WITH-IN THESE RULES WILL BE ASKED OR FORCED TO LEAVE THE FACILITY.



ADVISORY DIRECTORS
PARKER F. CARR
[illegible] CRAM, M.D
JERRY KELLEY
H. PHILIP MARTIN
LLOYD [illegible]
[illegible]
LARRY CARR
MILES CORY
[illegible] GATTERMAN
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LEON RANKIN
GARY CAPLINGER
MARY ALICE HAWES
RAYMOND BAUER

SUNRISE, INC.

523 MAIN
LARNED, KANSAS 6
(316) 285-3462
"A half-way house for men on the way back"

DELL FOX, president
LODE, vice-president
OL SCHOENTHALER, secretary
ERT PIVONKA, treasurer

DIRECTORS
NIS HAGERMAN
VERA GILES
RT LARSON
JACK DIPMAN
ALLAN SMITH
LARRY CARR

ADMINISTRATION DIRECTOR
KENNETH R. LEMON

TO SUNRISE CLIENTS

EFFECTIVE 11-22-83, ALL CLIENTS WILL BE OUT OF BED, HAVE THEIR ROOM CLEAN AND BEDS MADE BY 7:00 AM.

THE MEN WHO ARE WORKING NIGHTS DO NOT HAVE TO GET UP AT THIS TIME, BUT MUST MAKE BEDS AND HAVE ROOM CLEANED WHEN THEY GET UP.

ALL CLIENTS NOT WORKING A STEADY JOB WILL REPORT TO JACK TIDWELL AT 7:30 A.M. EACH MORNING FOR ONE (1) HOUR WORK AROUND THE HOUSE OR PREMILES.

THIS IS A REQUIREMENT OF YOUR PROGRAM. THOSE FAILING TO DO THIS WILL BE SUBJECT TO DISPLINARY ACTION.

Kenneth Lemon
Adm. Director

MONDAY:	GROUP GOVERNMENT	6:30 PM. TO 7:00 PM
MONDAY	GROUP COUNSELING	7:00 PM. TO. 9:00 PM.
THURSDAY	SUNRISE, AA MEETING	7:30 PM. To 9:00 PM.

ALL THE ABOVE YOU MUST ATTEND: PLUS ONE OUTSIDE MEETING

OTHER AA MEETINGS & NA MEETING

7:00 PM. TO 8:30 PM.

SUNDAY & WEDNESDAY LARNED STATE HOSPITAL 7:30 PM. TO 9:00 PM.
(VAN, LEAVES AT 7:00 PM.)

TUESDAY LARNED TOWN GROUP FRIDAY 7:30 PM. TO. 9:00 PM.
(5th & Broadway upstairs over the Chamber office)

SATURDAY ST. JOSEPH HOSPITAL GROUP 7:30 PM. TO 9:00 PM.

SATURDAY GREAT BEND 7:30 PM. TO 9:00 PM.
(THE VAN GOES TO THIS MEETING IF ENOUGH CLIENTS ATTEND)

SUNRISE, INC., ADDRESS 523 MAIN LARNED, KANSAS 67550
OFFICE PHONE (316) 285-3462 THIS IS FOR BUSINESS AND FOR JOB APPLICATIONS

PAY PHONE (316) 285-8980

NOTICE TO ALL STAFF AND CLIENTS

THERE WILL BE A FIRE DRILL ON THE 1ST. OF EACH MONTH. THERE ARE EVACUATION DIAGRAMS ON EACH FLOOR SHOWING THE EVACUATION ROUTE THAT YOU WILL TAKE ON EVACUATION THE BUILDING.

ALL CLIENTS AND STAFF ARE EXPECTED TO EVACUATE THE BUILDING IN THREE (3) MINUTES FROM THE SOUND OF THE ALARM.

Kenneth Lemon
KENNETH LEMON, CAC
ADMINISTRATION DIRECTOR
SUNRISE, INC.

Medical Center

50 Irving Street, NW.
Washington D.C. 20422

Veterans
Administration

April 17, 1984

In Reply Refer To:

Honorable Alan Cranston
Ranking Minority Member
Committee on Veterans Affairs
United States Senate
Washington, D.C. 20510

Re: Section 3 of S 2269

Dear Senator Cranston:

In response to your letter suggesting bereavement counseling for up to 6 months after death, I would like to share with you some of my views on the bereavement process.

Bereavement starts as soon as the patient and his loved ones are told that death is inevitable. All parties affected by this knowledge suffer and grieve because lifelong ties are about to be broken. The patient suffers from feelings of loneliness and isolation from his family and from helplessness in the face of his illness. His loved ones also suffer because of their inability to adequately help the patient. Family planning for the future is often delayed or ignored because plans must obviously exclude the dying patient. As time passes, the patient progressively deteriorates physically and mentally until only fragments of his personality remain. During this last period, the loved ones begin to hope that death will come soon. This wish often engenders guilt.

In light of these considerations, it is clear that bereavement counseling should start at the time a terminal illness is diagnosed, not after death. My staff and I have recognized this need for many years and reference is made to bereavement in the bracketed section of the attached article (p.1183) describing our oncology ward. Our concern about bereavement and the shortcomings in treating it have led us to develop a protocol to guide our management of grief and anguish. Hopefully, with adequate funds for personnel, this type of program could be widely implemented in VA medical centers. Briefly, we plan to foster an interaction among the patient, his loved ones and specially motivated nurses who are either trained or long experienced in dealing with the concerns of the terminally ill. Together, they will form a therapeutic alliance. This alliance will begin with the establishment of a trusting relationship. Subsequently, practical problems will be worked out, personality assets capitalized upon and remaining patient resources utilized. This leads into the therapeutic phase where preparation is made for the termination of the relationship. Discussion, in the therapeutic phase, centers around concepts of life, death and afterlife. The theory of eternal progression is often a gratifying speculation that encourages both patient and family toward achievement and optimism even in the face of imminent death. By forming a therapeutic alliance between the patient, mediating nurse and his family, both hidden and obvious personal values are brought into focus so that all affected individuals derive support and solace throughout the terminal illness and beyond. We stress that last achievements and struggles are worth the effort, that they can be satisfying and that they may be carried into the next phase of existence. In the final days, the therapeutic alliance between the nurse and the family helps them deal with their feelings of guilt and inadequacy in the face of death. By the time the patient dies, much of the bereavement process should have been accomplished, and the family should feel relief that the patient's suffering has ended. This should help them to make the adjustments needed to continue their lives.

To specifically answer your question, I agree that bereavement counseling is very important. Because bereavement is not yet adequately managed it could require six months of counseling, after death, for adjustments to be made. As indicated above, however, this is not optimal. Our goal is to develop techniques that will allow bereavement counseling to be concluded, in most cases, at the time of death. We are optimistic that this can be achieved.

Sincerely,

Martin H. Cohen

Martin H. Cohen, M.D.
Chief, Oncology Section

2C North

Does emotional involvement between patients and staff preclude objectivity? Not on 2C North, where empathy has resulted in creative —even groundbreaking—nursing care.

By Anita Johnston-Early

2C North is a unit that can boast of few physical amenities. The architecture is antiquated; private and semi-private rooms and bathrooms are scarce. It is where patients come for treatment if they have cancer of the lung, prostate, liver, or stomach, or mycosis fungoides, a rare lymphoma.

Some might reject 2C North at first glance, or cringe at sharing a room with three patients. A few would find it distasteful to walk down a corridor to a bathroom. Some would have to be convinced that the treatment here is very good and not easily duplicated elsewhere.

But because of the superb care given by a caring staff, the environmental inadequacies of 2C North are hardly noticeable.

2C North restores those whose emotional reserves have been severely depleted by the shock of knowing that they have cancer. Where the earth once had been crumbling beneath, 2C North builds a firm foundation. Nurses on 2C North are not afraid to touch and hold or to speak about cancer and dying. Baths and bedmaking are often delayed as nurse and patient sit side by side assuring, listening, and sharing. Together, we ask what can be done today to make life more pleasant, what can be achieved with the resources at hand. Nurse, patient, family, and doctor rejoice together when an x-ray shows that a tumor is shrinking. And when it is painfully clear that treatment has failed and there is no where to go but into somebody's arms, those arms are waiting on 2C North.

The 2C North nursing staff is involved. They are sometimes warned that involvement might mean a lack of objectivity, but they have learned long ago that the opposite is true. Involvement is not only productive, it is also natural. Yet since it can be draining, the nurses are advised and supported by a psychiatrist, who years ago was an intern on 2C North. With him, they learn to deal with their emotions and get to the core of problems. The staff are able to pool and complement their strengths so effectively that together, they have become an imposing force.

Empathy is the unit's most valuable characteristic. Indeed, it is difficult *not* to learn it; for superficiality is quickly abandoned in the face of acute hurt and need. Patients and families continually teach and reinforce the concept of empathy in one another. Roger and his mother are two of many we have learned from.

Roger was an unassuming 39-year old patient who came to us from Appalachia. His cancer was so widely spread that we could hope only for a transitory remission of his disease; that's all he ever had. After a six-week hospitalization for intensive chemotherapy, Roger was discharged to return every three weeks for maintenance treatment. Within a few months his cancer, again growing, was unresponsive to new treatment. Roger was not sorrowful. He did not complain. He just accepted what was happening.

He asked that his mother be called to share his last days with

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ANITA JOHNSTON-EARLY, RN, is oncology nurse investigator and protocol coordinator, Veterans' Administration Center, Washington, D.C.

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him. She arrived carrying only a paper sack. She remained at his side, helping the nurses bathe and turn his now edematous and jaundiced body. She slept in a chair when he slept. She coaxed broth into his ulcerated mouth and gently rubbed his aching limbs. A touch, a glance, words of assurance and encouragement communicated that this was just another hardship to be endured. They had put up with plenty before, and they could get through this now. Roger wasn't to worry, "because she'd be just fine." He would smile at her confidence and then sleep again for a while.

When it was obvious that he was dying, Roger called his mother to his side and whispered his good-bye. When he died, she turned from him, seeming to accept her fate as he had, and left his room carrying her paper sack.

It was hard for those of us who had shared those days with her to say good-bye. We felt a kinship with her and she with us. Many of our patients and families spend weeks, months, and even years undergoing treatment. The bonds between us grow, regardless of how much time we have together. During holidays, many family members return to reminisce and bring gifts. Occasionally, they telephone or write as new adjustments are being made in their lives. And then one day we realize we haven't heard from one of them in a long time, and we know that for him or her, adjustment is complete.

While the greatest nursing contributions we make are in day-to-day bedside care for patients, we have made other unique and worthy contributions. One had to do with the care of the patient with mycosis fungoides (MF). MF begins with skin tumors, ulcers, or plaques that are sometimes thick and leathery. Because MF is difficult to diagnose in its early stages, patients often spend years going from doctor to doctor. At diagnosis they may be bitter, depressed, and withdrawn.

The skin lesions break down, become infected, and drain. The odor is repulsive. Often a person's entire skin surface is involved. Intravenous therapy becomes difficult to administer, and bathing and topical application of creams tedious and unpleasant. Eventually the internal organs are affected. The disease now becomes fatal.

Alice is the research nurse in charge of MF patients on 2C North. She is young and pretty, with clear, smooth skin. It is impossible not to be struck by the physical contrast between patient and nurse. But Alice seems to see past the smelling, oozing lesions. She patiently instructs each person in the use of topical chemotherapy and creams, using video tapes that she has prepared. She listens attentively as patients repeat the instructions back to her. With proficiency she gives IV therapy in veins hidden beneath hard plaques.

Alice faithfully supports her patients through the slow and difficult months of electron beam therapy that sometimes further damages the skin by reddening or burning it. She gives her patients jobs to do to help them remain productive and offers suggestions on how to make positive changes in their lives. She helps her patients develop inner resources that strengthen their personalities. Based on her experience with MF, Alice has written several papers that not only provide guidance on various aspects of the disease, but also give insight into support of cancer patients in general.

Making a difference in each patient's care is the norm on 2C North. But the nurses also have unique opportunities to do clinical research that can affect the lives of many patients. One nurse conducting studies in lung cancer noticed that a large percentage of her long-surviving patients with small-cell lung cancer had stopped smoking at or before their cancer was diagnosed. All had previously been heavy smokers. She had not been asked to record this information, but because she knew her patients so well, this phenomenon became apparent to her. She began keeping records on new patients, and after several years, her suspicions were confirmed: The patients who had stopped smoking at or before diagnosis had a better response to treatment than those who continued to smoke. These results were published in a major medical journal and widely circulated by the press.* The finding prompted physicians to advise their patients that smoking abstinence was an aid to treatment. It encouraged scientists to test whether smoking abstinence was associated with longer survival.

Another challenge that became a triumph concerned patients whose tumors obstruct large and small airways so that their lungs can no longer accommodate oxygen, causing these patients to smother. While these individuals were clearly suffering, the medical and nursing staff often treated symptoms inadequately because they feared that narcotics would further interfere with respiratory function. Some stood by helplessly, but other nurses prodded the medical staff into action. Finally, all physicians and nurses became convinced that they were obligated to intervene aggressively and treat pain, anxiety, and shortness of breath.

I became principal investigator to study safety on the efficacy of continuous IV morphine in the patient with intractable pain and dyspnea. We formulated a plan to deliver continuous intravenous morphine to those patients for whom all other analgesic regimens have failed.** Patients were monitored so that medication would not depress an already compromised respiratory system. Pain was safely relieved as were anxiety and dyspnea. Our head nurse reported the preliminary results at an Oncology Nursing Society meeting. Yes, it was possible, with careful monitoring and titration of medication, to significantly relieve the suffering of these patients. This report was one of 40 publications initiated or aided by 2C North nurses.

2C North is a model nursing unit. In this environment, nurses can develop their full abilities regardless of academic background. They are given the opportunity to develop patient management programs and the flexibility to implement them. Nurses not only give care, they develop better care.

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*Johnston-Early, Anita, and others. Smoking abstinence and small cell lung cancer: an association. JAMA 244:2175-2179, Nov. 14, 1980.

**Paper presented at American Society of Clinical Oncology meeting, May 24, 1982.

Office of the
Administrator
of Veterans Affairs

Washington, D.C. 20420

Veterans
Administration

MAY 2 1984

Honorable George J. Mitchell
United States Senate
Washington, D.C. 20510

Dear Senator ~~Mitchell~~ George

Your letter of March 29, 1984, again raised a number of questions regarding VA provision of health care to veterans living in rural areas which are remote from VA medical facilities. A review of your questions suggests the importance of clarifying some key points involved in this subject.

In discussing provision of health care benefits to veterans, it must first be understood that VA has very limited legal authority to provide veterans with outpatient medical care and treatment for disabilities which are not service connected. 38 U.S.C. § 612(f). VA is authorized to provide comprehensive outpatient care only to very limited categories of veterans, most notably former POW's and veterans with service-connected disabilities rated at least 50 percent. In general, the scope of outpatient care VA can furnish any eligible nonservice-connected veteran is limited to medical services needed as a followup to a period of VA hospitalization and acute care to obviate a need for hospitalization. Thus, the nonservice-connected veteran is not eligible to receive VA outpatient care for many common disorders, such as the flu or a muscle strain, for example, for which one might consult a private physician.

In testimony and prior correspondence on the subject of establishing VA clinics in rural areas, Agency officials have perhaps tended to emphasize the demographic and related problems associated with such a concept. It should also be noted, as discussed above, that a VA or VA-contracted clinic would not have legal authority to provide the kind of comprehensive outpatient care to nonservice-connected veterans we believe you may have contemplated in raising questions on this subject. We would also emphasize that most veterans who do have eligibility to receive VA care for nonservice-connected disabilities, such as 50 percent service-connected veterans and those in need of followup care after VA hospitalization, would be eligible for fee-basis outpatient care if VA facilities are not geographically accessible.

Honorable George J. Mitchell

It is important to note that the two VA clinics in Utah about which you have asked are primarily devoted to providing followup care to veterans who have been hospitalized at the Salt Lake City VA Medical Center. Such clinics are simply one method the VA may use to provide such care. Other VA medical centers including the Togus VA Medical Center ordinarily provide such care through the fee-basis contract program. These considerations should set the subject of rural health care in better perspective. I trust they will also help clarify our view that a veteran residing remote from a VA medical center is not necessarily at a significant relative disadvantage in terms of access to outpatient care under VA auspices.

With these points as background, I am taking the liberty of enclosing a paper which responds specifically to your questions of March 29, 1984.

Sincerely,

Harry

HARRY N. WALTERS
Administrator

Enclosure

Questions and Answers

Question "What technical expertise is needed to develop national statistics on rural veteran populations? Does the VA have the technical capacity in-house to develop national statistics on veteran populations residing various distances from VA medical facilities along the lines which the Togus VAM&ROC provided me regarding Maine veterans. If not, how would the VA acquire this capacity?"

Response: The Veterans Administration maintains a wide variety of population statistics on the number of veterans in civilian life. Among the data available are estimates and projections of the veteran population of each state and county nationwide. These figures are differentiated by period of military service, and are updated annually based on a March 31 reference date.

The state and county veteran population data which we prepare are comparable to the statistics presented in the letter which Togus VA Medical Center Director John Bunger sent you on June 9, 1983. Our figures are available in somewhat greater detail, however. Enclosed for your information is a copy of our estimates of the veteran population for each county in Maine as of March 31, 1984. These figures are broken down by period of service.

In order to construct estimates of the veteran population residing exact distances from VA medical care facilities, we would have to develop an entirely new system. It is certainly possible for the VA, working with the Bureau of the Census to develop such a system. However, as Dr. Custis stated in testimony on April 11, 1984, such information would not be as important to us in planning as would be other determinants.

Question: "What would be the dollar costs to the VA of developing such statistics and what would be the value of such statistics to the VA in evaluating the availability of present VA health care delivery programs to rural veterans."

Response: The development of such a new system would undoubtedly be costly. At this time, however, we do not have a basis to provide a meaningful estimate of the cost involved.

Again, as we stated above, while such statistical data would be interesting, we do not believe it would be particularly valuable to the VA. We currently have statistical data on veterans by county which give us valuable information on how many veterans are living in remote rural areas.

Question: "Do you feel such statistics mentioned above could be used by this committee to target possible pilot VA program health-care delivery alternatives? What additional data would be helpful to the committee in this regard?"

Response: These statistics could theoretically be used as part of the criteria for conducting needs assessments studies for outreach clinics and other related VA health care initiatives. However, we would emphasize that the VA has developed and implemented a planning process called Medical District Initiated Program Planning

(MEDIPP). This new process has been very successful and we are committed to its continued use. We believe local need, as identified through the MEDIPP process, should be the determining factor for internal VA decision-making on where and how health care should be delivered to all veteran populations be they rural or urban.

Question: "Please provide more detail, with emphasis on the applicability of these projects to rural health care in Maine, on those alternatives which have been identified as having a current annual support in excess of $100,000 (St. Cloud VAMC: COPE; Hot Springs VAMC: Outreach to Rushville, Nebraska; Denver VAMC: Medivan; Salt Lake City VAMC: Outreach to Richfield and Roosevelt; and Tuscaloosa VAMC-Community Service Program)."

Response: As we stated earlier in this letter, medical centers throughout the country have used various methods to provide care, principally post-hospital follow-up care to veterans for nonservice-connected disabilities. The principal method used by the Togus facility, and it is certainly a good method, is the fee-basis contract care program. We would also note, however, that another approach being planned for providing care to veterans in Aroostook County, Maine, is a "sharing agreement" between Togus and the USAF Hospital at Loring Air Force Base, Loring, Maine. Under terms of this proposed agreement, the Air Force Hospital will provide services covering outpatient visits in general medicine and surgery, compensation and pension examinations and a limited amount of inpatient care.

Any option for service delivery is potentially available to VAMC Togus including these you mention. We rely upon the VAMC and the Medical District to plan the service delivery mechanisms to meet veteran health care demands based on a local determination of need.

Question: "Please advise me of any modifications to the operation of those outreach efforts from the descriptions provided by Salt Lake City Center Director Robert E. Lindsey in his prepared statement for the July 13, 1983, hearing (p. 126-137, S.Hrg. 98-450)."

Response: There have been no major modifications in operation of the rural health program at Salt Lake City since July 1983. Changes which have occurred have been related to improving the efficiency of management practices, enforcement of eligibility regulations, and cost containment. These changes are similar to those which have occurred within the medical center itself.

Question: "To what degree does the Salt Lake City VAMC find it necessary to rediagnose veterans referred by the Richfield and Roosevelt clinics?"

Response: The experience at Salt Lake City to date has not shown a need to rediagnose veterans who receive their care at the rural clinics. This is due to the close communication linkages between the Sale Lake City VAMC and the rural clinics and to the fact that most patients are receiving post-hospitalization care.

Question: "Have the operation of the clinics presented misleading impressions to nonservice-connected veterans regarding eligibility for VA treatment? What problems has the VA encountered in making accurate eligibility determinations and properly monitoring the provision of quality care?"

Response: The rural health clinics are designed to provide post-hospital follow-up services so that eligibility in most cases has already been determined. To avoid giving misleading impressions to nonservice-connected veterans, Salt Lake City has instituted an educational program to inform rural veterans of eligibility requirements. Regarding the provision of quality care, outreach health clinic physicians and physician assistants work closely with the supporting VAMC medical staff to assure continuity of care for patients discharged from the hospital to be followed in the rural clinics. This allows closer monitoring of changes in the patient's medical condition and earlier referral to specialty clinics to avoid emergencies and the need for rehospitalization. The Salt Lake City VA Medical Center's quality assurance section monitors clinic costs, workloads and medical practices on an ongoing basis. It also conducts administrative audits, patient care evaluation and utilization review studies.

Question: "Can the VA provide me a detailed breakdown of expenditures associated with a diagnostic clinic which would result in a 3-year $980,000 expenditure that would be generated by enactment of S. 523?"

Response: The breakdown of the estimated three-year cost (proposed time period of the program) of operating the experimental program is:

	Costs (000s of dollars)			
Year	Leasing[1]	Medical Care Services[2]	Other[3]	Total
1984	75	184	69	322
1985	75	184	69	322
1986	75	184	69	322
Total	225	552	207	984

[1] Estimated by Space Management; assumes no structural renovations would be required.

[2] Staff requirements at VA specifications estimated at $26,301 FTEE, FY 1984 EST.

[3] Other costs include: travel and transportation; communications; supplies and materials; equipment; and costs associated with the Advisory Committee authorized by the bill.

Question: "At what date can we expect final approval of this project by the VA? Is it the impression of the VA that the $105,000 FY 85 funding estimate included for this project in response Ig will be sufficient? Is the VA committed to funding for the expected 5-year life of this study? If so, at what level of funding for each year?"

Response: The Health Services Research and Development (HSR&D) Service received proposal IIR #82-113 from VAMC Togus on April 10, 1984. It is being reviewed presently. Only scientifically acceptable proposals are considered for funding and each quarter the HSR&D Service's Awards, Appeals, and Appointments Council reviews all such proposals and rank orders them according to funding priority. Funding is contingent on the availability of resources. Thus, it is not possible to give a date by which the project would be funded. We expect to know whether or not the proposal is scientifically adequate by mid-July. If adequate, it would be considered at the Council's meeting that quarter, and if sufficient resources are available it would be funded effective October 1, 1984. The proposal requests $930,695 over five years, with $442,276 requested for Kennebec Valley Regional Health Authority (KVRHA). Once funded, it is HSR&D Service's policy to support a project to completion, if progress is satisfactory and funds are available.

Question: "Under the parameters of the study, would it be possible to include Aroostook County among the areas included in this study? Would a mandated inclusion of Aroostook County jeopardize the scientific validity of this study?"

Response: We understand that Aroostook County is already included in the proposed study.

Question: "It is my understanding that as part of this research, veterans living in geographically remote areas of Maine will be encouraged to utilize the services of rural health clinics which have entered into "federation agreements" with Togus VAM&ROC. How would such "federation agreement" differ from the contractual agreement central to S. 523?"

Response: The proposed study would be of veterans eligible for outpatient care under the fee-basis program, and of veterans discharged from VAMC Togus and enrolled in the post-hopsital outpatient treatment program for nonservice-connected conditions. The KVRHA would coordinate the federation between VAMC Togus and each Rural Health Center. All Centers in Maine would be solicited for participation in this project. Contracts between VAMC Togus and each Center would state rights and responsibilities, centering on treatment plans, reimbursement levels, and in-service training. The primary difference between the study clinics, and a clinic such as that proposed by S. 523 is that the study clinics will only be providing care to veterans when eligibility for care for nonservice-connected conditions has been established.

MAINE

VETERAN POPULATION BY COUNTY --- MARCH 31, 1984

COUNTY	TOTAL VETERANS.	W A R V E T E R A N S									
		TOTAL.	VIETNAM ERA		KOREAN CONFLICT						
			TOTAL.	NO. SERVICE. IN KOREAN CONFLICT.	TOTAL.	NO. SERVICE. IN WORLD WAR II.	WORLD WAR II.	WORLD WAR I.	POST-VIETNAM. ERA.	SERVICE. BETWEEN. KOREAN. CONFLICT. AND. VIETNAM. ERA ONLY.	OTHER. PEACETIME. VETERANS.
TOTAL	153,000	125,300	46,000	42,000	29,000	23,000	58,000	2,000	10,000	16,000	1,000
ANDROSCOGGIN	13,620	10,950	3,970	3,740	2,380	2,040	5,020	140	950	1,500	220
AROOSTOOK	9,630	7,660	3,200	3,000	1,740	1,560	3,020	70	950	950	60
CUMBERLAND	30,440	24,870	8,790	7,920	5,810	4,430	12,190	340	2,070	3,140	360
FRANKLIN	3,550	2,880	1,060	980	710	580	1,270	50	200	450	30
HANCOCK	5,940	4,970	1,790	1,620	1,150	960	2,320	70	340	570	60
KENNEBEC	15,190	12,620	4,480	4,070	2,880	2,300	6,060	170	800	1,630	150
KNOX	4,640	3,940	1,320	1,240	850	690	1,920	80	190	460	50
LINCOLN	3,710	3,110	1,110	1,010	680	510	1,530	70	200	380	20
OXFORD	6,740	5,620	1,790	1,700	1,210	1,040	2,810	80	280	750	80
PENOBSCOTT	18,660	15,170	5,630	5,140	3,760	3,210	6,630	190	1,430	1,940	110
PISCATAQUIS	2,250	1,930	640	570	440	380	960	30	60	240	20
SAGADAHOC	3,930	3,220	1,570	1,310	820	620	1,260	40	290	380	40
SOMERSET	5,910	4,730	1,640	1,550	920	780	2,330	70	440	720	30
WALDO	3,630	2,950	1,090	1,020	780	590	1,320	30	280	380	20
WASHINGTON	4,950	4,140	1,510	1,400	970	820	1,830	90	310	450	50
YORK	20,370	16,690	6,480	5,950	3,680	2,900	7,630	220	1,140	2,370	160

NOTE: DETAIL MAY NOT ADD TO TOTAL SHOWN DUE TO ROUNDING. "OTHER PEACETIME VETERANS" IS COMPRISED OF THOSE WHO SERVED ONLY BETWEEN WORLD WAR I AND WORLD WAR II, AND THOSE WHO SERVED ONLY BETWEEN WORLD WAR II AND THE KOREAN CONFLICT.
LESS THAN 5.   ** LESS THAN 500.

II

Calendar No. 929

98TH CONGRESS
2D SESSION

S. 2514

[Report No. 98–487]

To amend title 38, United States Code, to enhance the management of Veterans' Administration medical treatment programs by providing for the referral of veterans to non-Veterans' Administration entities and arrangements for additional necessary services, to revise and clarify the authority for the furnishing of care for veterans suffering from alcohol or drug dependence, to require the Administrator to establish the position of Associate Director for Post Traumatic Stress Disorder, to require the Administrator to submit a report to Congress regarding programs of the Veterans' Administration providing hospice and respite care to certain veterans, and to authorize the Administrator of Veterans' Affairs to provide telecaption television decoders to totally deaf veterans in certain cases, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 30 (legislative day, MARCH 26), 1984

Mr. SIMPSON introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

MAY 25, 1984

Reported, under authority of the order of the Senate of May 11 (legislative day, April 30), 1984, by Mr. SIMPSON, with an amendment and an amendment to the title

[Strike out all after the enacting clause and insert the part printed in italic]

A BILL

To amend title 38, United States Code, to enhance the management of Veterans' Administration medical treatment programs by providing for the referral of veterans to non-

Veterans' Administration entities and arrangements for additional necessary services, to revise and clarify the authority for the furnishing of care for veterans suffering from alcohol or drug dependence, to require the Administrator to establish the position of Associate Director for Post Traumatic Stress Disorder, to require the Administrator to submit a report to Congress regarding programs of the Veterans' Administration providing hospice and respite care to certain veterans, and to authorize the Administrator of Veterans' Affairs to provide telecaption television decoders to totally deaf veterans in certain cases, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, ~~That (a) this Act may be cited as the "Veterans' Administration Health Care Amendments of 1984".~~

~~(b) Except as otherwise specifically provided whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.~~

~~REFERRALS AND ARRANGEMENTS FOR COMMUNITY SERVICES~~

~~SEC. 2. (a) Chapter 73 is amended by adding at the end of subchapter I the following new section:~~

~~"§ 4120. Referrals and arrangements for community services~~

~~"In order to enhance the management of Veterans' Administration care and treatment programs, the Administrator shall designate one office in each Veterans' Administration health care facility and in central office to coordinate and make arrangements for the provision of referral services to assist veterans, to the maximum extent practicable, in obtaining health and health-related services from sources outside the Veterans' Administration, not at Veterans' Administration expense, when such services are reasonably necessary in the treatment of veterans eligible for care under chapter 17 of this title. In carrying out this section, the Administrator shall place particular emphasis on the needs of veterans with service-connected disabilities rated at 50 per centum or more and veterans age sixty-five or older.".~~

~~(b) The table of sections at the beginning of chapter 73 is amended by adding after the item relating to section 4119 the following:~~

~~"4120. Referrals and arrangements for community services.".~~

~~ALCOHOL TREATMENT AND REHABILITATION~~

~~SEC. 3. (a) Section 620A is amended—~~

~~(1) by amending paragraph (1) of subsection (a) to read as follows:~~

~~"(1)(A) The Administrator, in furnishing hospital, nursing home and domiciliary care, and medical and~~

~~rehabilitative services under this chapter, may contract for care and treatment and rehabilitative services in halfway houses, at such per diem rates as the Administrator shall by regulation prescribe consistent with prevailing rates in the community.~~

~~"(B) For the purposes of this section, the term 'halfway house' means a treatment facility not under the direct jurisdiction of the Administrator, offering a community based, peer group oriented, residential program of treatment and rehabilitation for alcohol or drug dependence or abuse disabilities, which provides food, lodging, and supportive services in a drug- and alcohol-free environment for veterans recovering from active alcohol or drug abuse.~~

~~"(C) The maximum period for one treatment episode under the authority established by paragraph (1)(A) of this subsection shall be limited to sixty days.";~~

~~(2) by redesignating paragraph (2) of subsection (a) as paragraph (D);~~

~~(3) by striking out subsection (c);~~

~~(4) by redesignating all subsections, paragraphs, clauses, and cross-references accordingly; and~~

~~(5) by adding at the end the following new subsection:~~

~~"(b) The Administrator shall prescribe regulations, not later than twelve months after the date of enactment of this Act—~~

~~"(1) to establish maximum periods of treatment and rehabilitation for alcohol or drug dependence or abuse disabilities of a veteran eligible for care under this chapter consistent with the average periods of such treatment and rehabilitation experienced in programs not administered by the Veterans' Administration, to include specific maximum periods for—~~

~~"(A) detoxification to stabilize the veteran's condition;~~

~~"(B) acute inpatient care and treatment;~~

~~"(C) additional extended care and treatment in cases involving multiple and complex diagnoses; and~~

~~"(D) outpatient care and treatment including appropriate referral services under section 4120 of this title; and~~

~~"(2) to ensure that individual treatment plans are developed, implemented, and monitored (including at least one year of followup monitoring after discharge from inpatient care and treatment) for each veteran receiving care for alcohol or drug dependence or abuse disabilities.";~~

~~(6) in paragraph (5) of subsection (a) (as redesignated by paragraph (3) of this subsection), by striking out "authorized by this section" and inserting in lieu thereof "authorized by the amendment made by section 104 of Public Law 96-22 (93 Stat. 50)".~~

~~(b) Not later than September 30, 1984, and on September 30 of each subsequent year, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a comprehensive survey of all Veterans' Administration alcohol and drug treatment and rehabilitation programs, identifying by facility, the number of beds involved, the number of patients and episodes of care (whether inpatient-acute, inpatient-rehabilitation, or outpatient), the specific treatment modalities employed, average lengths of stay, and staffing requirements, together with a national summary of such information. The third such report shall contain in addition information on the effectiveness of the care and treatment furnished to veterans for alcohol or drug dependence or abuse disabilities in light of the regulations promulgated and implemented under subsection (b) of section 620A (as amended by this section), including information on the use of differential diagnosis, case-management treatment, lengths of stay, discharge planning, methods of monitoring the use of halfway houses under the authority of section 620A, and referral and followup programs.~~

~~(c) The section heading of section 620A and the item relating to such section in the table of sections at the beginning of chapter 17 are each amended by striking out the semicolon and "**pilot program**".~~

~~MEDICAL AND REHABILITATIVE DEVICES~~

~~SEC. 4. Section 601(6)(A)(i) is amended by inserting "devices for the hearing-impaired in the case of any veteran who is totally deaf (including telecaptioning television decoders)," after "prosthetic appliances,".~~

~~POSTTRAUMATIC STRESS DISORDER~~

~~SEC. 5. (a) Section 4101 is amended by adding at the end thereof the following new subsection:~~

~~"(g)(1) The Administrator shall establish in the Mental Health and Behavioral Sciences Service of the Department of Medicine and Surgery a position to be known as Associate Director for Posttraumatic Stress Disorder (hereinafter in this subsection referred to as "Associate Director") and shall appoint an individual to serve in such position. The rate of basic pay of the Associate Director shall not be less than the minimum rate of basic pay payable for a position in chief grade under the physician and dentist schedule set out in section 4107(b)(1).~~

~~"(2) The Associate Director shall develop policies, provide guidance, and coordinate the provision of services for the treatment of Vietnam veterans with posttraumatic stress dis-~~

~~order, including care furnished in inpatient posttraumatic stress disorder units.~~

~~"(3) The Associate Director shall coordinate, by medical region, inpatient care for eligible veterans suffering from posttraumatic stress disorder, and shall take steps to ensure that the provision of such care includes the use of treatment plans, referral procedures, and posttreatment followup care.~~

~~"(4) The Associate Director shall conduct special education and training programs on posttraumatic stress disorder for appropriate employees of the Department of Medicine and Surgery, including programs on diagnostic criteria and methodologies, referrals, and the formulation and implementation of treatment plans and followup care.~~

~~"(5) The Chief Medical Director shall establish a task force on the care and treatment of posttraumatic stress disorder. The task force shall include health care employees of the Veterans' Administration who are involved in the treatment or care of veterans suffering from posttraumatic stress disorder. The task force shall advise the Chief Medical Director on policies regarding—~~

~~"(A) the use of appropriate treatment modalities and the development of standards governing lengths of stay of veterans in Veterans' Administration health care facilities for care and treatment for problems related to posttraumatic stress disorder;~~

~~"(B) the coordination of treatment of posttraumatic stress disorder patients after discharge from inpatient care;~~

~~"(C) the monitoring and evaluation of treatment programs for posttraumatic stress disorder patients;~~

~~"(D) the conduct of health-services research making comparisons among various treatment modalities for posttraumatic stress disorder to determine proper treatment methods and length of stay;~~

~~"(E) ensuring proper diagnosis of posttraumatic stress disorder at all medical facilities including those which do not have programs dedicated specifically to the care and treatment of posttraumatic stress disorder; and~~

~~"(F) the necessity of, and appropriate standards governing referral of patients, including those receiving vocational rehabilitation in domiciliaries.".~~

~~(b) Not later than nine months after the date of enactment of this Act, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report evaluating the results of the implementation of this subsection.~~

~~REPORT ON VETERANS' ADMINISTRATION PROGRAMS FOR TERMINALLY ILL AND CERTAIN OTHER VETERANS~~

~~SEC. 6. (a) Not later than September 30, 1985, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report regarding programs of the Veterans' Administration (1) to furnish palliative and supportive care to terminally ill veterans and supportive care to members of such veterans' families, and (2) to furnish care to terminally and chronically ill veterans for brief periods in part for the purpose of providing a respite for members of the veterans' families in order to encourage them to maintain the veterans in their homes (in order to obviate the need for institutional care) to the maximum extent practicable.~~

~~(b) The report required by subsection (a) shall include—~~

~~(1) a review of Veterans' Administration policies and guidelines on the provision of care described in subsection (a);~~

~~(2) a review of the care furnished to the veterans described in paragraph (a) and any treatment modalities used to furnish such care, including a description of the services furnished in connection with such care;~~

~~(3) a comparison of the care provided to terminally ill veterans in hospice and nonhospice treatment programs, including a comparison of the routine and~~

~~ancillary services furnished as hospice care and the routine and ancillary services furnished to terminally ill patients in nonhospice treatment programs;~~

~~(4) an analysis of the lengths of stay of, and cost of care provided to, chronically and terminally ill veterans in programs described in subsection (a);~~

~~(5) an evaluation of whether and how the provision of care to terminally and chronically ill veterans described in subsection (a)(2) helps to obviate or delay the need for institutionalizing such veterans for a prolonged period;~~

~~(6) an explanation of how the care described in subsection (a) is or will be included in the overall plans of the Veterans' Administration for providing health care to elderly veterans in the future and the extent to which plans to furnish hospice and respite care are included in such plans;~~

~~(7) a review of the steps taken to coordinate the provision of the care described in subsection (a) with community providers of similar care; and~~

~~(8) proposals for such administrative or legislative action as the Administrator may deem appropriate in light of the findings and conclusions of such report.~~

That (a) this Act may be cited as the "Veterans' Administration Health Care Amendments of 1984".

(b) Except as otherwise specifically provided whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

COORDINATION OF VETERANS' ADMINISTRATION-COMMUNITY REFERRAL ASSISTANCE AND SERVICES

SEC. 2. (a) Chapter 73 is amended by adding at the end of subchapter 1 the following new section:

"§4120. Coordination of referral assistance and services

"In order to improve the provision, and enhance the management, of health-care and health-related services by the Veterans' Administration and other sources to veterans who are eligible for care under chapter 17 of this title, with a special emphasis on veterans who are 65 years of age or older, and who are determined by the Administrator to be in need of assistance under this section, the Administrator shall designate one organizational unit in each Veterans' Administration health-care facility for the purpose of coordinating the provision of referral assistance, and facilitating and helping to coordinate the provision of such services not at Veterans' Administration expense, to such eligible veterans when such referral is reasonably necessary for the health of such veterans. The Administrator shall carry out this section (1) in a manner consistent (A) with the policy of the United States, set forth in section 409(a) of Public Law 97–306, that the

Veterans' Administration shall maintain a comprehensive, nationwide health-care system for the direct provision of quality health-care services to eligible veterans, (B) with the mandate of section 4101(a) of this title that the Department of Medicine and Surgery shall provide a complete medical and hospital service for the medical care and treatment of veterans, and (C) with the United States Government's historic, firm commitment, and moral obligation, as embodied in this title, to provide care for veterans with service-connected disabilities, and (2) in conjunction with local, State, Federal, and private agencies providing and coordinating the provision of services to elderly persons and with other pertinent public and private agencies.".

(b) The table of sections at the beginning of chapter 73 is amended by adding after the item relating to section 4119 the following:

"4120. Coordination of referral assistance and services.".

ALCOHOL AND DRUG TREATMENT AND REHABILITATION

SEC. 3. (a) Section 620A is amended—

(1) by striking out "pilot" in subsection (a)(1) both places it appears;

(2) by striking out "fifth" and inserting in lieu thereof "seventh" and by striking out "pilot" in subsection (e);

(3) in subsection (f)—

(A) by inserting "(1)" before "Not"; and

(B) by inserting before the period "prior to the amendment of this section by the Veterans' Administration Health Care Amendments of 1984"; and

(C) by adding at the end the following new paragraph:

"(2) Not later than March 1, 1986, and March 1, 1987, the Administrator shall report to such committees on the findings and recommendations of the Administrator pertaining to the operation of the program authorized by subsection (a) during the preceding fiscal year and shall include in such report information for such year regarding average duration of participation of veterans, rates of successful rehabilitation, and any changes in average and maximum allowable charges per veteran under contracts entered into by the Veterans' Administration as part of such program."; and

(4) by adding at the end the following new subsection:

"(h) Not later than 12 months after the date of the enactment of this subsection, the Administrator shall prescribe regulations to provide guidelines for the treatment and rehabilitation of veterans for alcohol or drug dependence or abuse disabilities under this chapter in facilities over which the Administrator has direct jurisdiction. Such guidelines shall include guidance—

"(1) on the duration of such treatment and rehabilitation under this chapter, taking into account the duration of such treatment and rehabilitation in non-Veterans' Administration programs and identifying specifically duration in detoxification, inpatient-acute care, inpatient-rehabilitation and extended care, outpatient care, and followup services; and

"(2) on the provision of referral assistance and the development, implementation, and monitoring of individual treatment plans and followup for veterans receiving such care and treatment.".

(b) Not late than March 1, 1985, and March 1 of each subsequent year, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report containing a comprehensive survey of the activities during the preceding fiscal year of all Veterans' Administration-operated programs providing treatment and rehabilitation for alcohol or drug dependence or abuse disabilities, identifying, by facility, the number of beds involved, the number of patients and episodes of care (whether inpatient-acute, inpatient-rehabilitation, inpatient-extended, or outpatient), the specific treatment methodologies employed, average lengths of participation, rates of successful rehabilitation, and staffing levels and standards, together with a national summary of such information. The

third such report shall also contain information on the effectiveness of such treatment and rehabilitation in light of the regulations prescribed under subsection (h) of section 620A (as added by the amendment made by subsection (a)(4) of this section), including information on diagnostic methodologies employed, use of case-management approaches and discharge planning, lengths of participation, treatment results, methods used for approving, evaluating, and monitoring the use of non-Veterans' Administration facilities under section 620A, and referral and followup activities for veterans discharged from such programs and such facilities.

*(c) The section heading of section 620A and the item relating to such section in the table of sections at the beginning of chapter 17 are each amended by striking out the semicolon and "***pilot program***".*

MEDICAL AND REHABILITATIVE DEVICES

SEC. 4. Section 617 is amended—

(1) by redesignating such section as subsection (a); and

(2) by adding at the end the following new subsection:

"(b) In order to assist in overcoming the handicap of deafness, the Administrator may provide assistive devices, including telecaptioning television decoders, to veterans who are profoundly deaf and entitled to compensation on account of hearing impairment.".

POST-TRAUMATIC-STRESS DISORDER

SEC. 5. (a)(1) In order to enhance the Veterans' Administration's capability to diagnose and treat post-traumatic-stress disorder (hereinafter in this section referred to as "PTSD"), the Chief Medical Director of the Veterans' Administration shall establish in the Department of Medicine and Surgery a Special Committee on Post-Traumatic-Stress Disorder (hereinafter in this section referred to as the "Special Committee") and shall appoint qualified employees of the Department to serve on the Special Committee.

(2) The Special Committee shall assess, and carry out a continuing assessment of, the capacity of the Veterans' Administration to provide diagnosis and treatment to eligible veterans with PTSD and shall advise the Chief Medical Director regarding the development of policies, the provision of guidance, and the coordination of services for the diagnosis and treatment of veterans with PTSD in inpatient PTSD units, other inpatient psychiatric programs, outpatient mental health clinics, and readjustment counseling programs of the Veterans' Administration. The Special Committee shall also make recommendations to the Chief Medical Director for guidance regarding appropriate diagnostic and treatment methods and referral for and coordination of followup care and with respect to the evaluation of PTSD treatment programs, the conduct of research concerning such diagnosis

and treatment (taking into account the provisions of subsection (b) of this section), special programs of education and training on PTSD for employees of the Department of Medicine and Surgery and the Department of Veterans' Benefits (also taking into account such provisions), the appropriate allocation of resources for all such activities, and any specific steps that should be taken to improve such diagnosis and treatment and to correct any deficiencies in the operations of inpatient PTSD units.

(b) The Chief Medical Director of the Veterans' Administration shall establish and operate a National Center on PTSD (A) to carry out and promote research into, and the training of health-care and related personnel in, the diagnosis and treatment of veterans with PTSD, and (B) to serve as a resource center for and to promote and to seek to coordinate the exchange of information regarding all research and training activities carried out by the Veterans' Administration, and by other Federal and non-Federal entities, with respect to PTSD.

(c)(1)(A) Not later than 180 days after the date of the enactment of this Act, the Administrator shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report on the implementation of subsections (a) and (b).

(B) The report required by subparagraph (A) shall contain—

(i) a list of the members of the Special Committee,

(ii) the assessment of the Chief Medical Director of the Veterans' Administration, after consultation with the Special Committee, regarding the capability of the Veterans' Administration to meet the needs of Vietnam veterans, former prisoners of war, and other eligible veterans for inpatient and outpatient PTSD diagnosis and treatment (both through PTSD inpatient treatment units and otherwise) as well as a description of the results of any evaluations that have been made of PTSD inpatient treatment units in existence on the date of the enactment of this Act,

(iii) the plans of the Special Committee for further assessments of the capability of the Veterans' Administration to diagnose and treat veterans with PTSD,

(iv) the recommendations made by the Special Committee to the Chief Medical Director,

(v) a description of the steps taken, plans made (and a timetable for their execution), and resources to be applied to implement subsections (a) and (b), and

(vi) the assessment of the Administrator of the capacity of the Veterans' Administration to meet in all geographic areas of the United States the needs described in clause (ii) and any plans and timetable for increasing that capacity (including the costs of such action).

(2) Not later than February 1, 1986, and February 1 of each subsequent year, the Administrator shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report containing information updating the report or reports submitted under this subsection prior to the submission of such report.

REPORT ON VETERANS' ADMINISTRATION PROGRAMS FOR TERMINALLY ILL VETERANS

SEC. 6. (a) Not later than September 30, 1985, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report on programs of the Veterans' Administration to furnish palliative care, supportive counseling, and other medical services to terminally ill veterans and, pursuant to section 601(6)(B) of title 38, United States Code, supportive counseling to members of such veterans' families.

(b) The report required by subsection (a) shall include—

(1) a review of Veterans' Administration policies and guidelines on the provision of care, counseling, and services described in subsection (a);

(2) a review of the care, counseling, and services furnished, including the treatment modalities used and services furnished by the Veterans' Administration;

(3) an analysis and a comparison of the care, counseling, and services furnished with respect to terminally ill veterans in hospice and other Veterans' Administration programs, including a comparison of the routine and ancillary services, of the duration of inpatient and outpatient treatment and hospital-based home care, and of the cost of care furnished in such programs;

(4) an explanation of how the care, counseling, and services described in subsection (a) is or will be included in the overall plans of the Veterans' Administration for providing health care to older veterans in the future and the extent to which plans to furnish hospice care are included in such plans;

(5) a review of any steps taken to arrange for the exchange of information between Veterans' Administration facilities providing the care, counseling, and services described in subsection (a) and non-Veterans' Ad-

ministration facilities providing similar care, counseling, and services; and

(6) proposals for such administrative or legislative action as the Administrator may consider appropriate in light of the information provided in the report.

AUTOMOBILE ADAPTIVE EQUIPMENT

SEC. 7. (a) Subsection (c) of section 1903 is amended to read as follows:

"(c)(1) An eligible person shall not be entitled to adaptive equipment under this chapter for more than two automobiles or other conveyances (A) at any one time, or (B) except as provided in paragraph (2) of this subsection, in any four-year period.

"(2) If, in a case in which the limitation set forth in paragraph (1)(B) of this subsection precludes an eligible person from being entitled to adaptive equipment, the Administrator determines that, due to circumstances beyond the control of the eligible person, one of the automobiles or other conveyances for which adaptive equipment was provided in the applicable four-year period is no longer available for the use of such person, the Administrator may, as a matter of discretion and pursuant to regulations which the Administrator shall prescribe, provide adaptive equipment for such person for an additional automobile or other conveyance during such period.".

(b)(1) Except as provided in paragraph (2), the amendment made by subsection (a) shall take effect on October 1, 1984.

(2) In the case of a person who was provided adaptive equipment under chapter 39 of title 38, United States Code, for an automobile or other conveyance after September 30, 1980, but prior to October 1, 1984, and who has available for use such automobile or other conveyance on the date of the enactment of this Act, the first four-year period applicable to such person under subsection (c) of section 1903 of such title (as amended by subsection (a)) shall begin on the most recent date prior to October 1, 1984, on which such individual was provided such equipment.

DEFINITION OF VIETNAM ERA

SEC. 8. Section 101(29) is amended to read as follows:

"(29) The term 'Vietnam era' means (A) the period beginning on August 5, 1964, and ending on May 7, 1975, and (B) the period beginning on February 21, 1961, and ending on May 7, 1975, in the case of a veteran who served in the Republic of Vietnam during such period.".

READJUSTMENT COUNSELING

SEC. 9. (a) Section 612A(g)(2)(B) is amended—

(1) by striking out "and" at the end of clause (i);

(2) by striking out the period at the end of clause (ii) and inserting in lieu thereof a semicolon and "and"; and

(3) by adding after clause (ii) the following:

"(iii) assessments of whether or not individuals who—

"(I) are veterans who served on active duty (aa) during World War II or the Korean conflict (with particular emphasis on those who engaged in combat with the enemy), (bb) during any period and who were prisoners of war, or (cc) after May 7, 1975 (with particular emphasis on those who served in areas during periods in which members of the Armed Forces in such areas were subjected to danger from armed conflict comparable to the danger to which members of the Armed Forces have been subjected in combat with the enemy during a period of war), and

"(II) members of the Armed Forces serving on active duty who (aa) served on active duty during World War II or the Korean conflict (with particular emphasis on those who engaged in combat with the enemy) or after May 7, 1975 (with particular emphasis on those who served in areas during periods described in division (I)(cc) of this clause), or (bb) were prisoners of war,

need readjustment counseling and, if so, the Administrator's recommendations on the most desirable means *by which such needs should be met, taking into account the resources that would be required to meet such needs and specifically whether such persons should be made eligible for readjustment counseling under this section and, if so, what effect that eligibility would have on the availability of such services for Vietnam-era veterans. The Administrator may submit the assessments and recommendations described in subclause (iii) at any time prior to April 1, 1987.".*

(b)(1) Not later than 180 days after the date of the enactment of this Act, the Administrator of Veterans' Affairs and the Secretary of Defense shall submit to the appropriate committees of the Congress a joint report setting forth—

(A) their recommendations, taking into account the extent of the availability of Veterans' Administration resources to provide readjustment counseling to Vietnam-era veterans, on the appropriateness and desirability of extending eligibility for readjustment counseling under section 612A of title 38, United States Code, to individuals who are serving on active duty in the Armed Forces of the United States and (i) who also served on such active duty during the Vietnam era (as defined in section 101(29) of such title (as amended by section 8 of this Act)), or (ii) who also served on active duty after May 7, 1975, in an area

during a period in which hostilities (as defined in paragraph (2) of this subsection) occurred in such area;

(B) their determinations as to (I) whether, if eligibility for such readjustment counseling were so extended, the Veterans' Administration and the Department of Defense would enter into an agreement or agreements pursuant to which the Department of Defense would reimburse the Veterans' Administration for such counseling provided to such individuals while serving on active duty, (II) if so, whether or not such reimbursement would be made without the necessity of the Veterans' Administration providing the Department of Defense with the names of the individuals so counseled and, if not, whether or not a requirement that such names be provided would discourage active-duty personnel from requesting such services, and (III) the manner and extent to which the Veterans' Administration and the Department of Defense would undertake to carry out outreach activities to inform such individuals about the availability of such counseling; and

(C) any other information, determinations, or recommendations pertinent to the subject matter of the report that the Administrator and Secretary consider appropriate.

(2) For the purpose of paragraph (1), the term "hostilities" means a situation as to which the Administrator, in consultation with the Secretary, finds that members of the Armed Forces in such situation were subjected to danger from armed conflict comparable to the danger to which members of the Armed Forces have been subjected in combat with the enemy during a period of war.

SECURITY SERVICE PERSONNEL

SEC. 10. (a) Section 218 is amended to read as follows:

"§ 218. Security and law enforcement on property under the jurisdiction of the Veterans' Administration

"(a)(1) The Administrator, with the concurrence of the Attorney General, shall prescribe regulations to provide for the maintenance of law and order and the protection of persons and property on land and in buildings under the jurisdiction of the Veterans' Administration and not under the control of the Administrator of General Services (hereinafter in this section referred to as 'Veterans' Administration property'). Such regulations shall prescribe, but need not be limited to—

"(A) rules for conduct on Veterans' Administration property,

"(B) the penalties, within the limits specified in paragraph (2) of this subsection, for violations of such rules,

"(C) policies with respect to the exercise by Veterans' Administration security service officers of the enforcement and arrest authorities granted in subsection (b) of this section,

"(D) the scope and duration of training that is required for Veterans' Administration security service officers, with particular emphasis on dealing with situations involving patients, and

"(E) rules limiting the carrying and use of weapons by Veterans' Administration security service officers.

The rules prescribed under clause (A) of this paragraph, together with the penalties for violations thereof, shall be posted conspicuously on such property.

"(2) Whoever violates any rule prescribed under paragraph (1)(A) of this subsection shall be fined not more than $500 or imprisoned not more than six months (or such lesser amount or period of time as the Administrator prescribes in the regulations prescribed under paragraph (1) of this subsection), or both.

"(b) The Administrator may designate employees of the Veterans' Administration as Veterans' Administration security service officers. Such officers shall enforce Federal laws, and the rules prescribed under subsection (a)(1)(A) of this section, on Veterans' Administration property. Any Veterans'

Administration security service officer, subject to any restrictions under the regulations prescribed under subsection (a) of this section, may make an arrest, with or without a warrant, for any offense on Veterans' Administration property if (1) such offense occurs in such officer's presence, or (2) such officer has reasonable grounds to believe (A) that the offense constitutes a violation of any law of the United States or of any rule prescribed under subsection (a)(1)(A) of this section, and (B) that the person to be arrested has committed that offense.

"(c) With the agreement of the head of the agency concerned, the Administrator may use the facilities and services of Federal, State, and local law enforcement agencies when it is economical and in the public interest to do so.

"(d)(1) Notwithstanding subchapter I of chapter 59 of title 5, the Administrator, pursuant to regulations which the Administrator shall prescribe consistent with paragraph (2) of this subsection, may pay allowances for the purchase of uniforms to any Veterans' Administration security service officer who is required to wear a prescribed uniform in the performance of official duties.

"(2) Allowances that the Administrator may pay under paragraph (1) of this subsection shall not exceed—

"(A) at the time the individual is first employed as a Veterans' Administration security service officer, $400; and

"(B) at the beginning of the first fiscal year that begins after the individual has completed 12 months of service as a Veterans' Administration security service officer and at the beginning of each subsequent fiscal year, $200.".

(b)(1) The provisions of section 218 of title 38, United States Code, other than clause (2) of subsection (a) of such section, as in effect on the day before the date of the enactment of this Act shall remain in effect until the date on which the Administrator of Veterans' Affairs prescribes the regulations required to be prescribed by subsection (a) of such section as amended by subsection (a) of this section.

(2) The authority of the Administrator to designate officers and employees of the Veterans' Administration to act as special policemen under section 218(a)(2) of such title as in effect on the day before the date of the enactment of this Act shall remain in effect until the date on which the Administrator first exercises the authority under subsection (b) of section 218 of such title as amended by subsection (a) of this section.

(c) The item relating to such section in the table of sections at the beginning of chapter 3 of such title is amended to read as follows:

"218. Security and law enforcement on property under the jurisdiction of the Veterans' Administration.".

(d) Section 4107(g) is amended—

(1) in paragraph (1)—

(A) by striking out "or" in clause (A);

(B) by striking out the comma and inserting in lieu thereof a semicolon and "or" in subclause (iv) of clause (B); and

(C) by inserting after clause (B) the following new clause:

"(C) of employees providing security services, pursuant to section 218 of this title, in buildings under the jurisdiction of the Administrator (and not under the control of the Administrator of General Services) that are used for the purpose of providing health care,";

(2) by striking out "health-care" each place it appears in paragraphs (2)(A) and (4); and

(3) by inserting "or (C)" after "(B)" in paragraph (4).

COMPTROLLER GENERAL REPORT ON MEDICAL PERSONNEL STAFFING LEVELS

SEC. 11. Section 5010(a)(4)(C) is amended to read as follows:

"(C) Not later than fifteen days after the expiration of the period for the submission of a certification by the Director of the Office of Management and Budget under subparagraph

(B) of this paragraph, the Comptroller General shall submit to the appropriate committees of the Congress a report stating the Comptroller General's opinion as to whether the Director has complied with the requirements of such subparagraph in providing such certification and in providing to the Veterans' Administration such funded personnel ceiling.".

REPORT ON FEDERAL GOVERNMENT RESPONSIBILITY TO INDIVIDUALS WHO SERVED WITH VOLUNTARY CIVILIAN ORGANIZATIONS IN VIETNAM

SEC. 12. (a)(1) The purpose of this section is to provide a basis for the executive branch and the Congress to evaluate the question of United States Government responsibility, and alternative approaches, for providing individuals who served for a period of at least thirty days in the Republic of Vietnam during the Vietnam era as employees of voluntary organizations, determined by the Administrator of Veterans' Affairs, in consultation with the Secretary of Defense, to be organizations which provided significant assistance to the United States Armed Forces in the Republic of Vietnam during the Vietnam era, with Federal and other benefits and services (including, but not limited to, health care and monetary compensation for disabilities which may be related to exposure to dioxin or be the result of traumatic events), either through the Veterans' Administration or otherwise, and for assisting such individuals in connection with disabilities they may have incurred as a result of such service.

(2) In order to carry out the purpose stated in paragraph (1), the Administrator, the Secretary of Defense, and the Secretary of Health and Human Services, not later than 180 days after the date of the enactment of this Act, shall submit to the appropriate committees of the Congress a joint report on the question of United States Government responsibility and setting forth various alternative approaches (together with comments on the appropriateness and the advantages and disadvantages of each) and any recommendations by such officials for legislative and administrative action with respect thereto, for establishing a program for providing such benefits, services, and assistance to such individuals.

(b) For the purpose of this section, the terms "Armed Forces" and "Vietnam era" have the meanings given such terms in section 101 (10) and (29) (as amended by section 8 of this Act), respectively, of title 38, United States Code.

CONTRACT CARE IN PUERTO RICO AND THE VIRGIN ISLANDS

SEC. 13. Section 601(4)(C)(v) is amended by striking out "September 30, 1984," and inserting in lieu thereof "September 30, 1985,".

PAYMENT FOR THERAPEUTIC AND REHABILITATIVE ACTIVITIES

SEC. 14. (a) Notwithstanding any other provision of law, no amount of remuneration provided to an individual as a participant in a therapeutic or rehabilitative activity car-

ried out pursuant to section 618 of title 38, United States Code, shall be included in determining annual income for purposes of payments of pension (as defined in section 101(15) of such title).

(b)(1) Subsection (a) shall take effect on October 1, 1984, and shall cease to have effect on December 31, 1987.

(2)(A) In the case of each person who on January 1, 1984, was, or on a subsequent date prior to October 1, 1984, became, a participant in an activity under such section 618 and who either (A) continuously participated in such activity from January 1, 1984, or such subsequent date through September 30, 1984, or (B) terminated such participation for the purpose of entering into more remunerative employment, the Administrator of Veterans' Affairs shall pay to such person, from funds in the Veterans' Administration compensation and pension account, an amount equal to the amount of pension (as so defined) that such person would have been eligible to receive by reason of subsection (a) if it had become effective as of January 1, 1984.

(B) This paragraph shall take effect on October 1, 1984.

(c) Not later than February 1, 1987, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report, with respect to fiscal years 1985 and 1986, on the

implementation of subsections (a) and (b). Such report shall contain information regarding the numbers of individuals who participated in activities under such section 618, the numbers of such individuals who are in receipt of Veterans' Administration pension, the costs of excluding payments provided for participation in an activity under such section 618 from countable income for Veterans' Administration pension purpose, and the effect of so excluding such payments on the participation of veterans in such activities. Such report shall also and shall include any recommendations of the Administration for legislative or administrative action in light of information contained in the report.

(d) Section 618 is amended by adding at the end the following new subsection:

"(f) Neither a veteran's participation in an activity carried out under this section nor such veteran's receipt of remuneration as a result of such participation shall be considered as a basis for the denial or discontinuance of a total disability rating for purposes of compensation or pension based on the veteran's inability to secure or follow a substantially gainful occupation as a result of disability.".

HEALTH CARE IN REMOTE AREAS

SEC. 15. (a) The Congress finds that—

(1) many veterans with service-connected disabilities and other veterans eligible for certain health-care services from the Veterans' Administration, within the

limits of Veterans' Administration facilities, reside in areas of the United States that are geographically remote from health-care facilities over which the Administrator of Veterans' Affairs has direct jurisdiction;

(2) for many such veterans such health-care facilities are geographically inaccessible and for many other such veterans the inconvenience of travel to such facilities discourages them from seeking health-care services from the Veterans' Administration; and

(3) a study conducted by the Administrator of eligible veterans residing in remote areas and these veterans' utilization of Veterans' Administration health-care services would provide useful information on the feasibility and appropriateness of alternative approaches to furnishing health-care services to such veterans.

(b)(1) The Administrator shall carry out a study to develop information about veterans who reside in remote areas and are eligible for health-care services from the Veterans' Administration and to develop alternative approaches that could be adopted to furnish such veterans with such services. In carrying out the study, the Administrator shall—

(A) develop, to the maximum feasible extent, statistics on the number of eligible veterans who, during fiscal year 1985—

(i) reside less than 50 miles from the nearest Veterans' Administration medical facility,

(ii) reside between 50 miles and 100 miles from the nearest Veterans' Administration medical facility,

(iii) reside between 100 miles and 200 miles from the nearest Veterans' Administration medical facility, or

(iv) reside more than 200 miles from the nearest Veterans' Administration medical facility;

(B) develop, by each group of residences described in clause (A), statistics on the numbers of eligible veterans who, during such year—

(i) utilize Veterans' Administration medical facilities,

(ii) receive inpatient care in such facilities (including the typical lengths of stay of such veterans in such facilities),

(iii) receive outpatient care from such facilities, or

(iv) receive followup health-care services from such facilities;

(C) develop such further statistics and gather such additional information as the Administrator considers appropriate to carry out the study; and

(D) develop breakdowns of the statistics described in clauses (A) and (B) with respect to age, service connection, and financial need regarding the applicable veteran populations.

(2) Not later than January 1, 1986, the Administrator shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a full report on such study. Such report shall include—

(A) the statistics and breakdown developed and information gathered pursuant to paragraph (1);

(B) the Administrator's findings on the extent of the need for the Veterans' Administration to increase health-care services in remote areas; and

(C) the Administrator's findings and recommendations regarding the advantages and disadvantages of the Veterans' Administration contracting for and making other arrangements for the furnishing of health-care services to eligible veterans in remote areas.

(3) Not later than July 1, 1986, the Administrator shall submit to such committees a report describing an experimental program that could feasibly be carried out through projects in five remote areas, selected on the basis of the statistics, breakdowns, information, and findings included in the report submitted under paragraph (2), to demonstrate alternative approaches for the Veterans' Administration to furnish

health-care services to eligible veterans in remote areas. The report shall also include a description of the health-care services, and a detailed breakdown of the costs for them, that could be furnished under such an experimental program to such veterans in each such area, along with the recommendations (and the reasons therefor) of the Administrator regarding whether any such projects should be carried out and such recommendations for legislative or administrative action as the Administrator considers appropriate in light of the information contained in the report.

Amend the title so as to read: "A bill to amend title 38, United States Code, to require the Veterans' Administration to develop guidance for the provision of care to veterans suffering from alcohol or drug dependence, to require the Administrator to establish a Special Committee and a National Center for Post-Traumatic-Stress Disorder, to improve the Veterans' Administration's ability to protect persons and property on its premises, and to exempt from being counted for pension purposes remuneration received by veterans in certain rehabilitation therapy programs; and for other purposes.".

APPENDIX B

Calendar No. 929

98th Congress
2d Session

SENATE

Report
98-487

VETERANS' ADMINISTRATION HEALTH CARE AMENDMENTS OF 1984

REPORT

OF THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

TO ACCOMPANY

S. 2514

May 25, 1984.—Ordered to be printed
Filed under authority of the order of the Senate of May 11 (legislative day, April 30), 1984

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Calendar No. 929

98th Congress 2d Session | SENATE | Report 98-487

VETERANS' ADMINISTRATION HEALTH CARE AMENDMENTS OF 1984

May 25.—Ordered to be printed

Filed under authority of the order of the Senate of May 11 (legislative day, April 30) 1984

Mr. Simpson, from the Committee on Veterans' Affairs, submitted the following

REPORT

[To accompany S. 2514]

The Committee on Veterans' Affairs, to which was referred the bill (S. 2514) to amend title 38, United States Code, to enhance the management of Veterans' Administration medical treatment programs by providing for the referral of veterans to non-Veterans' Administration entities and arrangements for additional necessary services, to revise and clarify the authority for the furnishing of care for veterans suffering from alcohol or drug dependence, to require the Administrator to establish the position of Associate Director for Post Traumatic Stress Disorder, to require the Administrator to submit a report to Congress regarding programs of the Veterans' Administration providing hospice and respite care to certain veterans, and to authorize the Administrator of Veterans' Affairs to provide telecaption television decoders to totally deaf veterans in certain cases, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a committee substitute, and an amendment to the title, and recommends that the bill, as amended, do pass.

Committee Amendments

The amendments are as follows:
Strike out all after the enacting clause as follows:

* * * * * *

INTRODUCTION

S. 2514 was introduced on March 30, 1984, by the Chairman of the Committee, Senator Alan Simpson. As introduced, S. 2514 would have, first, required the Administrator of Veterans' Affairs to designate one office at each VA health-care facility to coordinate and arrange for certain health and health-related services in local communities at no expense to the Veterans' Administration; second, required the Administrator to issue regulations relating to the care for veterans suffering from alcohol or drug dependence; third, provided the Administrator with specific authority to provide assistive devices for hearing-impaired veterans, including telecaptioning television decoders, to those who are totally deaf; fourth, directed the Administrator to establish the position of Associate director for Post-Traumatic-Stress Disorder (PTSD); and fifth, directed the Administrator to submit a report to Congress regarding VA hospice and respite programs for terminally ill and chronically ill veterans.

On February 7, 1984, Senator Alan Cranston, the Committee's Ranking Minority Member, together with Committee members Senators Randolph, Matsunaga, and DeConcini, introduced S. 2269. As introduced, S. 2269 would have, first, expanded the definition of the Vietnam era for the purposes of title 38, United States Code, so as to include the period beginning on July 8, 1959, and ending on August 4, 1964, for those who served in Vietnam at any time during that period; second, authorized the VA to continue to provide counseling or mental health services to family members for a period of up to 6 months following a veteran's death in cases in which the veteran's family members had been receiving such services from the VA in connection with the veteran's care or counseling; third, provided persons still on active duty in the Armed Forces who served during the Vietnam era with eligibility for VA readjustment counseling and authorized the Administrator to provide such eligibility to persons who served in the Armed Forces after the Vietnam era in combat or combat-like situations; fourth, made permanent the VA's current, pilot-program authority to contract with non-VA halfway houses and other community-based programs for treatment and rehabilitation of veterans with alcohol or drug abuse or dependency disabilities; fifth, provided the Administrator with new authority to increase rates of pay, for recruitment and retention purposes, for protective services employees at VA health-care facilities; sixth, modified the due date of a recurring Comptroller General's report on the Director of the Office of Management and Budget's compliance with certain staututory requirements relating to funded personnel ceilings for the VA's Department of Medicine and Surgery; seventh, required the Administrator to develop criteria pursuant to which applications for grants for the construction, remodeling, expansion, or alteration of State veterans' home facilities could be awarded on a basis other than first-come, first-served; and eighth, directed the Administrator and the Secretaries of Defense and of Health and Human Services to submit to the Congress a joint report setting forth and evaluating various alternative approaches pursuant to which the Federal Government might provide benefits, services, and assistance relating to disabilities that possibly result from certain aspects of service in Vietnam in individuals who were present there during the Vietnam era as civilian employees of the Federal Government or of organizations that provided significant assistance to U.S. Forces.

On January 24, 1984, Senator Alan Simpson introduced S. 2210. As introduced, S. 2210 would have revised and clarified the eligibility of certain disabled veterans for automobile adaptive equipment.

On February 8, 1984, Senator Rudy Boschwitz introduced S. 2278. As introduced, S. 2278 would have made permanent the VA's current, pilot program authority to contract for veterans in non-VA halfway houses and other community-based programs for treatment and rehabilitation of alcohol or drug abuse or dependency disabilities.

On March 27, 1984, Senator Cranston, with Senator Matsunaga's cosponsorship, submitted Amendment No. 2850, to S. 2269. Amendment No. 2850 would have first, improved and clarified the Administrator's authority to provide security on VA property through a force of VA protective services officers and authorized a special uniform allowance for them; second, provided a 1-year extension, until September 30, 1985, of the VA's authority to provide certain fee-basis health care to veterans in Puerto Rico and the Virgin Islands; third, specified that any remuneration received by VA patients is a rehabilitation therapy program under section 618 of title 38, United States Code, shall not be counted as income for the purpose of VA pension; and fourth, mandated that the VA establish a national center for research into post-traumatic-stress disorder (PTSD), for training VA health-care personnel in appropriate treatment for veterans with PTSD, and for promoting and coordinating the exchange of information on PTSD research and required the VA to assess and report on its ability and capability to provide diagnosis and treatment to veterans with PTSD.

On February 17, 1983, Senator George Mitchell introduced S. 523. As introduced, S. 523 would have required the Administrator to establish an experimental program to determine the feasibility of furnishing diagnostic health-care services to certain veterans in areas geographically remote from VA health-care facilities. This legislation was addressed at a Committee hearing on July 13, 1983.

On April 11, 1984, the Committee held a hearing, chaired by Senator Simpson, to receive testimony on S. 2514, S. 2269. S. 2210, S. 2278, and Amendment No. 2850 to S. 2269. Testimony was received from Dr. Donald Custis, Chief Medical Director of the VA; Dr. Ewald W. Busse, Dean Emeritus, Duke University Medical Center and Chairman, Geriatrics and Gerontology Advisory Committee to the Veterans' Administration; Terrie Wetle, Ph.D., Division of Health Policy, Harvard University Medical School; Leonard Saxe, Ph.D., Office of Technology Assessment; Sandra K. Hill, R.N., M.B.A., Chair, Board of Trustees, Baltimore Alcoholism Treatment Center, Baltimore, Md., and Director, Alcoholism Treatment and Recovery Program, Suburban Hospital, Bethesda, Md.; Leo Ruffing, Association of Halfway House Alcholism Programs of North America, Inc; John R. Smith, incoming Director, Center for Trauma Recovery, VA Medical Center, Cleveland, Ohio; Dr. Martin Cohen, Chief, Oncology Service, VA Medical Center, Washington, D.C.; Sharron Dreyer, B.S.M., Assistant Administrator for Patient Care Services, Hospice of Northern Virginia; and representatives of The American Legion, the Veterans of Foreign Wars, the Disabled American Veterans, and the Paralyzed Veterans of America.

After carefully reviewing the testimony, the Committee met in open session on May 9, 1984, and voted unanimously to report favorably S. 2514 with an amendment in the nature of a Committee substitute S. 2514, as reported, consists of provisions derived with modifications from S. 2514, S. 2269, S. 2210, S. 2287, Amendment No. 2850, and an amendment offered by Senator Mitchell, which was offered in lieu of S. 523.

SUMMARY OF S. 2514 AS REPORTED

Basic Purpose

The basic purpose of S. 2514 as reported (hereinafter referred to as "the Committee bill") is to maintain and improve the quality and efficiency of health-care services provided by the Veterans' Administration to eligible veterans. The Committee intends that the Committee bill would, first, enhance the VA's capability to ensure that eligible veterans with certain complex health-care needs are provided with the most appropriate kinds and levels of care and that such care is provided in a coordinated fashion and, second, enhance the VA's health-care planning processes by examining the demand for certain kinds of health and health-related services.

Summary of Provisions

Included in the Committee bill are provisions which would:

1. Improve the provision of VA and non-VA health-care and related services to veterans, with special emphasis on those 65 years of age or older in need of referral assistance, by requiring the Administrator to designate one unit in each VA health-care facility to coordinate referrals of veterans to non-VA entities for care not at VA expense and to help coordinate veterans' care through such entities; and specify that the Administrator is to implement this authority in a manner consistent with the United States' commitment to provide a comprehensive, nationwide health-care system for direct care to veterans and its obligation to provide care for service-connected disabilities.
2. Extend for 2 years, through fiscal year 1987, the VA's authority, currently a pilot-program authority, to contract with halfway houses and other community-based facilities for the treatment and rehabilitation of veterans with alcohol or drug abuse or dependency disabilities; require reports by March 1, 1986, and March 1, 1987, on the fiscal years 1985 and 1986 experiences, respectively, under this authority; and delete references to this program as a "pilot" program.
3. Require the Administrator to issue regulations setting forth guidelines relating to VA treatment and rehabilitation of veterans with alcohol or drug abuse or dependence disabilities, including guidance on duration of treatment and rehabilitation, referral assistance, individual treatment plans, and followup for veterans receiving care and treatment; and require a report by March 1, 1985, and annually thereafter, on the experiences of all VA drug or alcohol treatment programs and, in the third such report, on the effectiveness of VA treatment and rehabilitation.
4. Authorize the VA to provide devices, including telecaptioning televisioin decoders, to assist profoundly deaf veterans who are entitled to VA compensation on account of hearing impairment to overcome the handicap of deafness.
5. Require the VA's Chief Medical Director (CMD) to establish a Special Committee on Post-Traumatic-Stress Disorder (PTSD) to advise the CMD on VA programs and policies regarding PTSD treatment and research and to establish and operate a National Center on PTSD to carry out and promote research and training and help to coordinate the exchange of information on PTSD research; and require reports, first within 180 days of the date of enactment, and then by February 1, 1986, and annually thereafter, on the Special Committee and

National Center and on the VA's capability and capacity to provide PTSD diagnosis and treatment.

6. Require a report by September 30, 1985, on VA efforts, in both its hospice and other programs, to provide palliative care, supportive counseling, and other medical services to terminally ill veterans and supportive counseling to their family members.

7. Specify that veterans eligible for adaptive equipment for their automobiles are entitled to a maximum of two such adaptions at any one time or within a 4-year period unless, as a result of circumstances beyond the veteran's control, the veteran no longer has use of one of these two vehicles, in which case the Administrator would be authorized to provide the veteran with an adaptation for a third vehicle.

8. Expand the definition of the Vietnam era for the purposes of title 38, United States Code, to include the period beginning on February 21, 1961, and ending on August 4, 1964, in the case of those who served in Vietnam during that time.

9. Require the Administrator, not later than April 1, 1987, to assess and report on the need for readjustment colunseling among veterans and active-duty personnel who served during World War II or the Korean conflict (particularly those who were in combat), who are former prisoners of war, and who served after the end of the Vietnam era in combat or combat-like situations.

10. Require the Administrator and the Secretary of Defense to submit a joint report, within 180 days after enactment, on (A) the appropriateness and desirability of extending eligibility for VA readjustment counseling to active-duty personnel who either served during the Vietnam era or served at a later time in combat or combat-like situations, and (B) on how, if eligibility were extended to these personnel, the VA and the Department of Defense would arrange for VA services to be provided, including how the VA would be reimbursed, and how VA and DOD would publicize the availability of services.

11. Improve and clarify the VA's authority to provide security on VA property through a force of VA security officers by mandating the issuance of regulations relating to security matters, authorizing a special uniform allowance for certain VA security service officers, and authorizing the Administrator, when and to the extent necessary for recruitment and retention purposes, to adjust the rates of pay of VA security service officers on a geographical or national basis.

12. Modify the due date of a recurring report to the Congress from the Comptroller General on the compliance of the Director of the Office of Management and Budget with certain statutory requirements relating to funded personnel ceilings for VA health-care personnel.

13. Require the Administrator and the Secretaries of Defense and of Health and Human Services, within 180 days after enactment, to submit a joint report on the question of U.S. Government responsibility for providing benefits for disabilities which may be related to exposure to dioxin or to traumatic events for individuals who were present in Vietnam for at

least 30 days as employees of voluntary organizations and, to the extent any such responsibility is identified, on how Federal or other benefits should be provided.

14. Extend for 1 year, through fiscal year 1985, the VA's authority to provide certain contract health-care services to veterans in Puerto Rico and the Virgin Islands.

15. Require the VA to conduct a 39-month demonstration project—and submit by February 1, 1987, a report on the first 2 years experience—under which the income received by veterans for their participation in VA incentive and compensated work therapy programs would not be counted as income for the purpose of VA pension programs.

16. Specify that a veteran's participation in a VA incentive or compensated work therapy program will not be considered a basis for denying or discontinuing a total disability rating for VA compensation or pension purposes.

17. Require the Administrator to submit by January 1, 1986, a report describing the results of a study of the utilization of VA health-care facilities by veterans who live in locations remote from those facilities and, by July 1, 1986, a report describing a possible experimental program through which the VA could offer health-care services, at five sites, to veterans in areas remote from existing VA facilities.

DISCUSSION

Coordination of Veterans' Administration-Community Referral Assistance and Services

Section 2 of the Committee bill, which is derived with modifications from section 2 of S. 2514 as introduced would add a new section—section 4120, "Coordination of referral assistance and services"—to title 38, United States Code, pursuant to which the Administrator would be required to designate one organizational unit in each VA health-care facility to help coordinate referral assistance by the VA to eligible veterans and to facilitate and help coordinate the provision of non-VA care and related services when such assistance is necessary for the health of eligible veterans. Special emphasis would be placed on assisting veterans 65 years of age or older.

The Committee has received information from a variety of sources, including witnesses who presented testimony at the Committee's June 1982 hearing on the aging veteran, concerning difficulties in organizing and managing the provision of comprehensive health-care services, particularly for elderly veterans. Such services are often fragmented due to the variety of providers, delivery sites, and payment mechanisms involved, and the multiple and complex health-care needs of the patients. With regard to such fragmentation, Dr. Ewald Bussee, Dean Emeritus, Duke University Medical School, and Chairman, Geriatrics and Gerontology Advisory Committee to the Veterans' Administration, testified as follows at the April 11 hearing in support of S. 2514 as introduced:

> This is a serious problem, not only within the Veterans' Administration but in our entire health care system, particularly in what we call long-term care which usually involves elderly people. I believe that the Veterans' Adminis-

> tration can make numerous contributions to improving the well-being of our elderly veterans as well as other disabled people and for this reason, I very strongly urge this effort be supported and expanded.

Dr. Terrie Wetle of the Harvard Medical School, who also testified stated:

> The Veterans' Administration is certainly the nation's largest single coordinated health care system. It is a major provider of geriatric institutional based care, but has only begun to emphasize community based services. It is also recognized that elderly veterans are quite likely to have multiple entitlements and eligibilities, including VA benefits, Medicare, Medicaid, social security and services under title 3 of the Older Americans Act, and others. To ensure the availability of the broad array of services required by the elderly I think it is imperative that the VA develop and improve linkages with community based providers.

Attempts to address the fragmentation problem have resulted in such solutions as problem-oriented medical records and improved discharge planning. These practices are links between patient medical care needs, recommended medical services, and treatment plans. Yet some monitoring activity still is necessary, particularly to ensure that recommended services are sought and received by the patient. On an individual patient level, the skills of a social worker often provide the cohesive element to indentify and bring together sources of a particular health-care service and the personal attention that are sometimes necessary to ensure that patients referred for specific care both seek it and receive it. Indeed, the VA, in its April 11 testimony stated that the VA's social work services have seen that "part of their responsibilities and their overall patient treatment and planning, which includes discharge planning, is to develop linkages with the community that will enable the placement of patients into the community following their hospital care."

The Committee believes that such linkages, which are established in individual cases, may also be useful in the aggregate for a patient population at specific medical centers. The VA acknowledged during testimony before the Committee that there is no systematic effort at each VA medical center to put the experiences of individual social workers or the social work service in place at the level of aggregrate or interagency planning. Further evidence in testimony received by the Committee indicated that in certain VA facilities and for certain individuals, referral information has not been collected and organized in a way that would make it available more generally and in a more understandable fashion to providers and patients with differing levels of knowledge and skills.

With the growing size of the aging veteran population and existing statutory eligibilities, the Committee is aware that the VA may not have the capacity or resources available at each VA facility to provide all services to all otherwise eligible veterans who seek care from the VA. Thus, it is the Committee's intent that this new section would result in structured arrangements being fashioned between VA facilities and various public and private local agencies to help ensure that referrals for non-VA care are made efficiently and effectively and that, as appropriate, VA and non-VA health and health-related services are provided in a well-coordinated and effective fashion. The Committee expects the VA, in carrying out this provision, to address both the current fragmented referral effort and the anticipated increased demand by encouraging the exercise of two coordinating responsibilities–internal, among VA staff, and external, with non-VA providers. By raising the focus for these two coordinating responsibilities above the individual patient level, the aggregate experience of all patient referral activities is expected to result in better integrated, more comprehensive referral patterns within a VA medical facility and outside of VA health-care facilities to augment VA services or to provide referral assistance to veterans who are not eligible for particular VA services.

It is the Committee's intent that the internal coordinating responsibility will aid in planning and implementing appropriate discharges of VA patients by identifying for these patients all potential sources of medical and social services in their communities that might provide needed post-hospital care. The external coordinating responsibility is intended to promote greater VA-community interaction and result in an increase in the access to a number and variety of community services for veterans in need of community care. The Committee believes the more active participation by the VA in helping guide veterans to appropriate services which may not be offered by the VA, or to appropriate community-based services in the cases of veterans with limited eligibility for VA services would make an important contribution to the coordination and provision of care for these veterans. The collection and dissemination of information on sources of care should also be an aid to the provision of services for non-veterans as well. It is the Committee's intent that this provision provide an opportunity for the individual VA medical facilities and the VA as a whole to act as catalysts in addressing and resolving the problem of fragmentation of services, especially with respect to elderly veterans.

The Committee emphasizes that, as provided in the Committee bill, implementation of this provision is required to be accomplished in a manner consistent (A) with the policy of the United States, set forth in section 409(a) of Public Law 97–306, that the Veterans' Administration shall maintain a comprehensive, nationwide health-care system for the direct provision of quality health-care services to eligible veterans, (B) with the mandate of section 4101(a) of title 38, United States Code, that the VA's Department of Medicine and Surgery shall provide a complete medical and hospital service for the medical care and treatment of veterans, and (C) with the U.S. Government's historic, firm commitment and moral obligation to provide care to veterans with service-connected disabilities.

Alcoholism Treatment and Rehabilitation

Section 3 of the Committee bill, which is derived in part and with modifications from section 5 of S. 2269, S. 2278, and section 2 of S. 2514 as introduced would extend for 2 years, through September 1987, the VA's present discretionary authority to contract with halfway houses and other community-based facilities for the treatment and rehabilitation of veterans with alcohol or drug abuse or dependence disabilities and would require the Administrator to submit to Congress fiscal years 1985 and 1986 reports on the experience under this contract authority, including such matters as the rate of successful rehabilitation of participants and costs per veteran. It would delete the references in current law to this program being a "pilot" program. It would also require the Administrator to prescribe regulations providing guidelines for VA-operated treatment and rehabilitation programs for veterans with alcohol or drug dependence or abuse disabilities to include guidance on the duration of treatment, kinds of treatment provided, use of individual treatment plans, and followup for veterans receiving care and treatment; and would require the Administrator to report to Congress on the activities of all VA alcohol and drug treatment programs. The Committee notes that the term "followup" is intended to refer to any efforts made by the VA, after the completion or termination of treatment or rehabilitation, to contact the veteran regarding his or her health status and possible need for further services.

Contract Program

Public Law 96-22, the Veterans' Health Care Amendments of 1979, established a 5-year pilot program for the treatment and rehabilitation of veterans with alcohol or drug dependence or abuse disabilities. Under this pilot program, the VA was provided with specific authority to contract with halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities for alcohol and drug treatment and rehabilitation for veterans. Public Law 96-22 also required the Administrator to report to Congress, by March 31, 1983, on the effectiveness of this pilot program; the due date of that report was subsequently postponed by section 6 of Public Law 97-251, to March 31, 1984. Provisions in S. 2514 as introduced, S. 2269, and S. 2278 would have made this authority permanent.

In connection with the Committee's April 11 hearings, Ken Schonlau, President of the Association of Halfway House alcoholism Programs of North America, Inc. (approximately 100 of the Association's 324 members had contracts with VA medical centers under this authority), submitted written testimony which strongly endorsed proposals to make the contract programs permanent. He further suggested that (1) local VA medical centers accept State facility licensing and program certification as quality assurance mechanisms, (2) the program be expanded to include social detoxification services, and (3) the duration of stay in the program remain 60 days with a discretioanary 30-day extension, if necessary.

Joseph Collins, Executive Director of the California Association of Alcoholic Recovery Homes, submitted testimony to the Committee based on information obtained from a survey of 15 members of the Association which had contracts with the VA. He recommended:1

> 1. The pilot program should be made a permanent part of the VA's overall health service program.

2. Rates for services should be established on the basis of actual costs in communities in which contracting facilities are located.

3. Criteria for quality of services and allowable lengths of stay in contracted facilities should be fully coordinated with States' alcoholism/drug authorities, most particularly where States have established quality assurance programs. The allowable length of stay of a veteran in a community/based alcoholism recovery program should be studied and reassessed.

4. The types of services provided under contracts should be expanded to include, at least social model detoxification services.

5. Eligibility procedures should be established which do not require that a veteran first enter a VA hospital or inpatient unit.

6. Followup studies and other analyses should be closely coordinated with State alcohol/drug authorities.

7. The words "halfway house" should everywhere be replaced with the phrase "recovery home/halfway house" which, he asserted, has become the accepted generic term.

8. Serious consideration should be given to an appropriate, but fairly major, expansion of funds allocated to contracts under this program.

In an April 10, 1984, response to a letter from Senator Alan Cranston, then Chief Medical Director Dr. Donald Custis responded to Mr. Collins' report on his Association's survey which was contained in an earlier letter to Senator Cranston:

> That report provides a number of evidences of significant treatment benefits and of cost effectiveness realized through the selective use of contract linkages with non-VA community-based programs. We believe the findings provide a firm basis for requesting that the pilot contract authority provided by section 620A of Title 38 of United States Code, be made permanent.

In testimony provided to the Committee at the April 11 hearing, Dr. Custis modified his support for making the program permanent and endorsed instead "a three-year extension of this program so that periodic reviews of the program could occur."

In light of the fact that the Committee did not receive until after the april 11 hearing, and just prior to the Committee's May 9 meeting to consider this legislation, the VA's report to Congress, due on March 31, 1984, on the effectiveness of the pilot program, the Committee was, therefore, unable to take into account the findings of the report. In view of the additional issues that the Committee believes merit additional review, and the VA's recommendation to extend the program for a period of years rather than make it permanent, the Committee determined it to be more appropriate at this time to extend, for an additional 2 years, the VA's authority to provide such services on a contract basis. This will enable the Committee to review the VA's report and to consider further various specific issues pertaining to the future of the program and quality of care provided by contract facilities.

As of January 1983, 6,000 veterans had been treated under the authority of the pilot program. As of February 15, 1984, the VA had approved 280 contracts between private sector facilities and individual VA medical centers. The cost of the program is expected to total $5.7 million in fiscal year 1984. In light of the large number of veterans participating in the program, the large number of such contracts, and the significant cost to the VA, the Committee intends to monitor closely the quality of care provided in the program, the effectiveness of the care, and the program's growth, and strongly encourages the VA to do the same. The Committee expects that the VA should itself be periodically monitoring the individual halfway houses, including the quality of care, the duration of treatment, the cost of care, and any increases in those costs. The Committee encourages the VA to use the guidelines the VA has set up for the monitoring of the community residential-care program as a model for the development of specific guidelines to aid in the monitoring of the halfway houses.

Regulations

In 1967, with the establishment of a Staff for Alcoholism and Related Disorders to provide central coordination of VA alcoholism treatment efforts, the VA formalized its efforts to provide treatment for veterans with alcoholism. In 1970, Congress provided funding for five specialized alcohol dependence treatment programs (ADTP's). There are currently 102 ADTP's in operation within VA medical facilities.

According to then-Administrator Robert P. Nimmo in a March 12, 1982, response to a January 1982 request from Senator Alan Simpson for specific information on the VA's alcohol treatment efforts (reproduced below), during fiscal year 1980 the VA treated 125,961 veterans for alcoholism or an alcohol-related medical problem as a primary diagnosis. This included diagnosis of alcoholism, alcoholic psychosis, alcoholic cirrhosis, and nonpsychotic organic brain syndrome due to alcohol. This did not include veterans treated for alcohol-related cases of heart disease, pancreatitis, gastric ulcer, peripheral neuropathy, esophagal varices, injuries due to driving while intoxicated, and other alcohol-related disorders. Mr. Nimmo stated that the total number of patients with these other alcohol-related disorders was significant but that information was not then available on a current basis.

23

Office of the
Administrator
of Veterans Affairs

Washington, D.C. 20420

Veterans
Administration

MARCH 12 1982

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Honorable Alan K. Simpson
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Thank you for your request for information on the VA's alcoholism treatment program. The requested medical statistics and budget data are enclosed as a separate unit.

I am particularly appreciative of the opportunity to describe the development of the VA's services for veterans' health through diagnosis and treatment of this important medical problem.

Alcoholism's immediate and long-term effects on both physical and emotional health are so grave that many physicians and public leaders identify it as the second most serious health problem in America, ranking just behind heart disease in prevalence and in associated health costs. The short- and long-term effects of chronic alcohol abuse are visible in all medical, surgical, and psychiatric wards and clinics. They range from injuries sustained in an automobile driven by an intoxicated person to liver disease and organic brain damage.

During the late 1960's and early 1970's, the VA responded to calls from Congressional committees, national veterans organizations, and individual veterans and their families, for more definitive treatment for alcoholism. Uninterrupted, alcoholism is associated with a shortened life span and often leads to complicating medical and psychiatric diseases which are difficult and expensive to treat and which further aggravate the overly stressed families, employers, and society in general.

Whenever Congress appropriated monies for the activation of a specialized medical program for treatment of alcoholism in veterans, we have, on a priority basis, activated such programs at VA medical centers across the country. Special attention has been given to those areas where the need for such a program was justified by the case load of veterans with alcohol-related diseases and where there was a shortfall in locally available treatment resources. I take a special interest in the continuing integrity of the distribution and utilization of such budget and staff.

Again, I want to thank you for the opportunity to report to you on the current status of this program which is so important to American veterans.

Sincerely,

Robert P

ROBERT P. NIMMO
Administrator

Enclosures

ENCLOSURE TO RESPONSE TO SENATOR ALAN K. SIMPSON: SPECIAL QUESTIONS ON ALCOHOLISM

1. How many veterans utilized the VA health-care system in FY '80 for treatment of alcoholism, or an alcohol-related medical problem, as a primary diagnosis? Please distinguish between service-connected and non-service-connected veterans.

Answer: 125,961 veterans utilized the VA health-care facilities during FY 1980, for treatment of alcoholism or an alcohol-related medical problem*, as a primary diagnosis.

31,394 had service-connected status
94,567 had non-service-connected status

Of the 72,134 veteran inpatients:

15,246 had service-connected status
56,888 had non-service-connected status

Of the 53,827 veteran outpatients:

16,148 had service-connected status
37,679 had non-service-connected status

A. How many of these veterans were inpatients? Please distinguish between VA hospitals, VA domiciliaries, and VA nursing homes.

Answer: 72,134 were inpatients:

70,009 were discharged from VA hospitals

1,911 were discharged from VA domiciliaries

214 were discharged from VA nursing homes

B. How many of these veterans were outpatients?

Answer: 53,827 were outpatients

*This includes diagnoses of alcoholism, alcoholic psychosis, alcoholic cirrhosis, and non-psychotic organic brain syndrome due to alcohol. It does not include veterans hospitalized or treated in outpatient clinics for alcohol-related cases of heart disease, pancreatitis, gastric ulcer, peripheral neuropathy, esophageal varices, injuries due to driving while intoxicated, and related disorders. Although the total number of such patients is significant, these diagnostic categories are not regularly coded to identify which cases are caused by alcohol abuse. Therefore, they are not directly retrievable subsets of data from currently submitted reports.

2. What percent were these veterans of the total number of patients treated in the VA health-care system in 1980? Please distinguish between service-connected and non-service-connected veterans.

Answer: Of the 2,724,713 veterans who used VA health care facilities in FY 1980, 4.6% were treated for alcoholism or for alcohol-related diseases*.

Of the 178,381 inpatients with service-connected status, 8.5% were alcohol-related.

Of the 445,988 inpatients with non-service-connected status, 12.8% were alcohol-related.

Of the 1,150,989 outpatients with service-connected status, 1.4% were alcohol-related.

Of the 949,355 outpatients with non-service-connected status, 4.0% were alcohol-related.

A. What percent of the total number of inpatients were these veterans? Please distinguish between VA hospitals, VA domiciliaries, and VA nursing homes.

Answer: Of the 624,369 inpatients in VA hospitals, VA domiciliaries, and VA nursing homes, 11.5% were alcohol-related cases.

Of the 613,699 VA hospital patients, 11.4% were alcohol-related.

Of the 6,606 domiciliary patients, 28.9% were alcohol-related.

Of the 4,065 VA nursing home patients, 5.2% were alcohol-related.

B. What percent of the total number of outpatients were these veterans?

Answer: Of the 2,100,344 outpatients, 2.6% were alcohol-related cases.

*As noted in answer to question #1, data on alcohol-related disorders are limited to four diagnostic categories.

3. Please define the term "alcohol-related disorders." What diagnosed illnesses fall within this category?

Answer: Alcoholism is an illness characterized wholly or in part by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun. The illness is characterized by chronicity, progression, and by a tendency toward relapse. Patient typically has an associated physical disability and shows impaired emotional, occupational, and/or social adjustments as a direct consequence of persistent and excessive use of alcohol.

(Veterans Administration definition: Used as Annual Census question in 1970, 1973, 1975, 1977, 1980).

Alcohol-related disorders are those diseases and injuries in which alcohol consumption is considered to be the most important cause or in which it contributes significantly to the development of the disease or disorder. The degree of constancy with which alcohol use is identified as causative may be high (as in alcohol dependence, alcoholic cirrhosis, alcoholic psychosis, or nonpsychotic organic brain syndrome due to alcohol). However, a significant proportion of a number of other medical conditions may result from alcohol abuse (as in esophageal varices which occur following the development of alcoholic liver disease; peripheral neuropathies which occur following the development of alcohol-caused malnutrition and vitamin deficiency; pancreatic disease caused by the toxic effects of alcohol on the pancreas; or primary disease of the heart muscle due to the toxic effects of alcohol on the myocardium of the heart).

Research has demonstrated significant correlations between alcoholism and the frequency of cancer, particularly of the head and neck.

Research on hypertension demonstrates that excessive use of alcoholic beverages is associated with substantially higher prevalence of hypertension.

Alcohol-related injuries include up to 40% of third degree burns, and victims of automobile accidents, falls, fights, and home injuries.

This range of alcohol-related disorders is the common experience of medical practice. Alcoholics, or patients whose illness is alcohol-related, occupy between 20 and 60 percent of the adult beds in acute general care (non-VA) hospitals, even in hospitals not located in areas with heavy concentrations of alcoholics.

Are such illnesses included in the statistics for questions 1 and 2?

Answer: Only the four high-frequency complications of chronic alcohol abuse are included in the medical statistical reports such that the cause of the disorder (i.e. alcohol) is regularly identified and coded on the chart. Data on alcoholism, alcoholic psychosis, alcoholic cirrhosis, and nonpsychotic organic brain syndrome are retrievable on the basis that they are, by definition, alcohol-related. Those individual cases of esophageal varices, hypertension, peptic or gastric ulcers, and other disorders which are ascribable to alcohol are not immediately retrievable from the total categorical group because they are not regularly coded as to specific etiology, and are therefore not available from the VA's recurring reports.

4. How many of the veterans who utilized the VA health-care system in FY '80 were also determined to have an alcohol-related medical problem as a secondary diagnosis? Please distinguish between service-connected and non-service-connected veterans.

Answer: 38,234 veterans treated and discharged from VA hospitals during FY 1980 had an alcohol-related medical problem as a secondary diagnosis. This is limited to those diagnoses of alcoholism, alcoholic psychosis, nonpsychotic organic brain syndrome due to alcohol, and alcoholic cirrhosis. The other alcohol-related disorders are not retrievable from the existing data base, as noted in Answer #3.

A. How many of these veterans were inpatients?

Answer: All patients identifiable from current statistical reports were hospital inpatients.

Please distinguish between VA hospitals, domiciliaries, and VA nursing homes.

Answer: The data represent hospital discharges only. No reports on secondary diagnoses are available on discharges from VA domiciliaries or VA nursing homes.

B. How many of these veterans were outpatients?

Answer: No reports are immediately available on secondary diagnoses for outpatients.

5. What was the average daily patient census (ADPC) in FY '80 for veterans being treated for alcoholism or an alcohol-related medical problem as a primary diagnosis?

Answer: The average daily patient census from AMIS was 5,955 during FY 1980. However this identifies only the diagnostic categories of alcoholism, alcoholic psychosis, and nonpsychotic organic brain syndrome due to alcohol. The other diseases (alcoholic cirrhosis, et al.) are not retrievable statistics.

What was the average length of stay for such veterans?

Answer: The average length of stay for the diseases noted above for the 5,955 was 26.0 days.

Please distinguish between service-connected veterans and non-service-connected veterans and between VA hospitals, VA domiciliaries, and VA nursing homes.

Answer: These data are not available from within current recurring biomedical reporting systems.

6. What was the ADPC in FY '80 for all the veterans in VA facilities who were determined to have alcoholism or an alcohol-related medical problem? Please include both those veterans who had alcohol abuse related problems as primary diagnoses and those who had alcohol abuse related problems as secondary diagnoses.

Answer: The ADPC for veterans, by secondary diagnoses, is not provided in current medical statistical reports. The information is collected at all field stations but is not analyzed for reporting to Central Office.

7. What was the rate of recidivism for those veterans treated for alcoholism or an alcohol-related medical problem in VA alcohol treatment programs during FY '79 and FY '80?

Answer: Data for the recidivism rate are not currently analyzed for biomedical statistical reports.

8. Are there any figures that demonstrate increased employment rates or other quantifiable evidence of effective social integration for those veterans treated for alcoholism in VA alcohol treatment programs during FY '79 and FY '80?

Answer: A 9-12 month treatment followup study, currently in draft, reports on 996 veterans initially hospitalized in VA alcoholism treatment programs during FY 1979 and FY 1980. The analysis of data indicates:

	At Admission	At Followup
Unemployment	42.1%	22.2%
Employed Part-Time	10.5%	8.4%
Employed Full-Time	27.6%	43.7%
Disabled and not Working	14.0%	14.7%
Retired	5.6%	7.5%
Average Monthly Income	$625	$823
Living Alone	34.2%	24.6%
Married	31.2%	38.5%
Divorced/Separated	51.1%	44.6%
Continuous Family Problems	25.7%	12.0%
Arrested During Past Two Years	46.9%	12.2% (During Past Six Months)
Jailed or in Prison During Past Two Years	33.2%	10.0% (During Past Six Months)

Are you aware of such data for alcohol treatment programs other than through the VA? How does the VA compare?

Answer: Comparable data are shown by a treatment followup report on community alcoholism treatment programs funded by the National Institute on Alcohol Abuse and Alcoholism.

Analysis of followup findings in that report (Rand Corporation) indicates:

	Six Months Followup		Eighteen Months Followup	
	Intake	Followup	Intake	Followup
Unemployed	54.0%	37.0%	57.0%	43.0%
Days Worked Last Month	8.7%	12.4%	7.9%	11.4%
Income Last Month	(Not Available)		$265	$424
Separated/Divorced	39.0%	39.0%	38.0%	39.0%

9. What is the VA's rate of recovery for veterans who are treated for alcoholism? Are you aware of such data for alcohol treatment programs other than through the VA? How does the VA compare?

Answer: The ultimate test of alcoholism treatment programs is their success in producing sobriety among their patients.

A 24-month followup report on outcome of VA alcoholism treatment programs operating in FY 1977 and FY 1978 revealed that 53% of patients evaluated were abstinent for the prior 30 days or more.

A 9-12 month followup report on outcome of VA alcoholism treatment programs operating in FY 1979 and FY 1980 revealed that 59.1% of the veterans evaluated were abstinent for the prior 30 days or more.

A treatment followup study performed by Rand/Stanford Research Institute for the National Institute on Alcohol Abuse and Alcoholism's funded programs indicates that at 6 months followup 37% of the patients were abstinent for the prior 30 days or more. At 18 months followup 21% of the patients evaluated were abstinent for the prior 30 days or more.

The VA's programs would seem, from this outcome comparison, to perform quite satisfactorily.

10. Are there any requirements that a veteran must fulfill to be treated in the VA alcohol treatment program?

Answer: Requests for treatment of alcoholism are medically and administratively processed in the same manner as requests for treatmont of any other disability, disease or defect susceptible to cure or decided improvement. When veterans apply voluntarily for treatment, they are fully informed of program goals, ethics and norms of behavior, and instructed concerning patient responsibilities and penalties for infractions of program rules.

A. Is concurrent participation in Alcoholics Anonymous mandatory?

Answer: Concurrent participation in Alcoholics Anonymous (AA) is actively encouraged and expected of all admissions. However, it is not mandatory (i.e. a veteran will not be refused treatment on the basis of non-participation in AA).

B. Is Antabuse or other similar medication mandatory during treatment?

Answer: Antabuse is a medication which is most appropriately used as an adjunct to ambulatory therapeutic techniques. It is not a complete or definitive treatment for compulsive drinking or other alcohol abuse disorders. Antabuse is in general a safe and useful part of treatment. However, it is contraindicated in patients with psychosis or brain damage sufficient to impair judgment or understanding. It is generally contraindicated in the presence of severe coronary heart disease and may be contraindicated in the presence of: diabetes mellitus, epilepsy, hypothyroidism, nephritis, liver disease, and pregnancy.

In the absence of such medical contraindications, Antabuse may be a mandatory requirement for an individual patient to remain in the alcoholism treatment program when this action can be demonstrated to be in the individual's best interest (i.e. previous demonstration of repeated relapses and inability to comply with the treatment plan for sustained sobriety).

C. What, if any, post-treatment followup procedures are utilized?

Answer: Aftercare followup contacts are utilized with each patient following treatment. These occur at least quarterly for the first year following discharge from treatment. In addition to continued post-treatment support for discharged patients, this information provides an important data base for use by each local program. The evaluation of the treatment outcome of former patients is a dynamic or continuous process. Analysis of this data base provides guidance for each program by permitting comparison of the actual results of the program with the desired results. With such information, the program monitors its own operation and regularly modifies or changes treatment activities as appropriate.

Have there been proposals to implement such requirements? If there have not, why not?

Answer: Proposals to mandate concurrent participation in AA have not been implemented because of several important factors:

1. AA proposes that the principles of voluntarism (self-declaration as an alcoholic) and substantial privacy (anonymity) are important to sustaining progress up the 12 steps. Forcing an alcoholic veteran to present himself regularly at an AA meeting would not assure the development of any continuing affiliation or membership after the initial controls were loosened.

2. Many newcomers to AA drop out shortly after arrival, according to the nationwide 1980 AA survey, which indicated that "about half the newcomers remain more than 3 months, sober or not, roughly the same as 1977." Therefore, initial attendance does not assure success. Veterans Administration program staff identify AA as an important rehabilitation modality and an important bridge toward sustained sobriety. However, there are a sizable number of veterans who initially reject the AA program when it is outlined and described. Within this group a number successfully complete the inpatient program otherwise and sustain sobriety without AA. Concerns that the AA group is not personally acceptable as a rehabilitation activity is often followed, within a few days, by a favorable reconsideration and by participation. In summary, rejection of the applicant for alcoholism treatment at the outset, on the basis of such a mandate, would likely deny treatment to a significant number of veterans who are motivated toward recovery, but who are at least initially refractory to AA referral.

The question of mandating Antabuse has been discussed in 10 B above.

11. What is the procedure by which a veteran is admitted to a VA alcohol treatment program?

Answer: A. Any eligible veteran who is diagnosed to have alcoholism and who requests treatment for that disease may be admitted to a VA alcohol dependence treatment program. Two questions must be addressed when the veteran presents himself at the VA medical center's Assessment and Admission Center:

1. Does the patient have sufficient clinical evidence of alcoholism, is he desirous of treatment, and sufficiently motivated; is he cooperative and compatible within the expectations and requirements of the needed program of treatment?

2. Is the potential patient an eligible veteran, for the level of care considered appropriate?

B. The applicant for treatment is provided with a discussion of the program's treatment philosophy, and the physical and functional characteristics of the program, including a review of those schedules and procedures which anticipate the patient's participation and compliance. The initial orientation is noted in the clinical chart, with some measure of the patient's participation and response.

12. What was the total expenditure for alcohol abuse treatment in the VA health-care system during FY '80?

Answer: $157,419,000

What percent of the total Department of Medicine and Surgery (DM&S) FY 1980 budget was that expenditure?

Answer: 2.53%

Can this figure be broken down to alcohol abuse treatment expenditures as a percent of the total FY '80 budgets in VA hospitals, VA domiciliaries, and VA nursing homes?

Answer: Cost distribution figures on alcoholism treatment are available only on a total appropriations basis.

13. Where does VA alcohol abuse treatment fit into the VA health-care system priority list?

Answer: Apart from regulations governing veteran priorities for VA care, there is no "VA health-care system priority list."

This health-care program complies with Section III of Public Law 94-581, codified at 38 U.S.C. 4133, which proscribes discrimination in the admission of otherwise eligible alcohol dependent veterans to VA health care facilities. Those veterans who suffer from the various medical disabilities are admitted to treatment when it is clinically appropriate. The same Public Law provides for a scheme of priorities for treatment of veterans. Those priorities are observed by the VA professional and administrative personnel when applicants for treatment are clinically assessed.

When a nonservice-connected veteran applies for treatment of alcoholism or an alcohol-related disorder, the initial clinical examination determines whether hospitalization is required. If there is an open bed on the specialized treatment ward, he is admitted for acute care and further study. However, if a veteran with a service-connected disability applies for similar treatment, he has priority for any available bed.

A one-year limit on post-hospital outpatient treatment is implemented for all nonservice-connected disorders pursuant to section 612(f), of title 38, United States Code. The law provides, however, that outpatient care for nonservice-connected conditions may be provided beyond the one-year limit when the attending physician determines that there is a need for additional treatment and the exception is authorized. Some alcoholic veterans need a longer period of outpatient treatment and this extension of eligibility is granted in those cases.

A significant number of nonservice-connected alcoholic veterans are admitted directly to ambulatory care, when, as authorized by law, the initial examination indicates that immediate treatment will serve to obviate the need for hospitalization.

14. There seems to be a strong commitment by the VA to allocating health-care resources to the treatment of alcoholism and alcohol-related medical problems despite the fact that most recipients of such care are non-service-connected veterans. Please explain the VA's philosophy on this issue. Outline the historical development of the VA's alcohol treatment program. In light of the constrained fiscal resources encountered these days and anticipated in the foreseeable future, has there been any rethinking of the VA role in this area?

Answer: The VA's provision of care and treatment for alcoholism to veterans proceeds from two concerns, i.e. the life-shortening effects of alcoholism and the handicapping, expensive biomedical and psychosocial consequences of alcoholism.

a. Mortality: It has been firmly established that clinically identified alcoholics, as a group, suffer higher mortality rates than the general population. The evidence suggests that alcohol consumption itself, and its direct physiological and psychological effects, are responsible for a substantial portion of the elevated mortality.

A 4-year followup, recently reported by Rand Corporation, of alcoholics treated in programs funded by the National Institute on Alcohol Abuse and Alcoholism, revealed the mortality rate of a cohort group of alcoholics to be 2.5 times greater than expected at 4 years following admission to a treatment program. When the deaths were analyzed for underlying cause, 57 percent of the deaths in the cohort were related, or were probably related, to alcohol.

b. Biomedical consequences: As noted earlier, there are numerous biomedical or systemic disease consequences from the excessive use of ethanol. Alcoholic cirrhosis is the eighth leading cause of death in adults. When a review was made of all VA inpatients discharged during FY 1980 with the principal diagnosis of alcoholism, and whose length of inpatient stay was 180 days or more, the following findings were noted:

The average number of diagnoses was 3.77 per patient.

The primary clinical service from which the patient was finally discharged was:

internal medicine	78 patients
surgery	6 patients
psychiatry	336 patients
neurology	7 patients
rehabilitation medicine	7 patients
spinal cord injury	7 patients
intermediate medicine	84 patients

A secondary diagnoses included:

343 diagnoses of diseases of the digestive system
192 diagnoses of mental disorders
131 diagnoses of diseases of the circulatory system
127 diagnoses of diseases of the nervous system
118 diagnoses of diseases of the respiratory system
64 diagnoses of endocrine, nutritional and metabolic diseases
28 diagnoses of infective and parasitic diseases
27 diagnoses of accidents and violence
21 diagnoses of neoplasms

Compensation and pension status of the 525 discharges was:

44.6% were either: SC, NSC/SC,
0% SC/NSC, NSC-Pension, or
0% SC/NSC-No Pension
55.4% were NSC-No Pension

Alcoholism is often initially invisible as the etiology of pancreatic or liver disease, or heart disease, or the suicidal behavior of a veteran referred as an emergency. Frequently, acute withdrawal symptoms are associated with other medical disorders in need of crisis management. In the setting of a medical urgency at the time of clinical assessment, there are, oftentimes, unresolved questions of service-connected/nonservice-connected status which require hours to resolve. In such settings the veteran may be accepted for admission, with definitive resolution of the service-connected questions to be obtained as soon as possible thereafter. The philosophy of the VA on the issue of allocating resources to the treatment of alcoholism and alcohol-related medical problems is, simply, that alcoholism is one of the most common illnesses currently challenging the practice of medicine. It presents in many disease forms, often without clear etiologic labels, and in varying degrees of urgency for care. It affects both service-connected and nonservice-connected veterans, without regard. It is quite often associated with health problems in the aging population (i.e. its highest VA prevalence is in the domiciliaries).

The VA's alcoholism treatment program began formally in 1967 when the VA established a Staff for Alcoholism and Related Disorders, in Central Office. This was responsive to growing convictions among health care professionals that it was necessary to treat alcoholics in medical settings. In parallel with the initiatives for recognition and treatment of heroin dependence, the U.S. Senate Subcommittee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare identified significant problems of alcohol and drug abuse in servicemen and in veterans, and proposed added efforts for prevention and treatment of these disorders. Specific directives were subsequently provided (i.e. from S1125), that "alcohol abusers and alcoholics who are suffering from medical conditions shall not be refused admission or treatment, solely because of their alcohol abuse or alcoholism, by any private or public general hospital which receives support in any form from any programs supported in whole or in part by funds appropriated to any Federal department or agency", in amendment to the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment Act, in 1973 (93rd Congress).

In addressing the VA budget for FY 1970, the Congress authorized budget for activation of 5 specialized alcohol dependence treatment programs (ADTPs). With program-specific Congressional mandates, the VA activated 9 additional ADTPs in FY 1971, 18 more in FY 1972, 21 in FY 1973, 13 in FY 1974, 6 in FY 1975, 1 in FY 1976, 5 in FY 1977, 21 in FY 1979, 1 in FY 1980, and 2 in FY 1981. There are, presently, 102 ADTPs in operation, integrated within the VA's health care facilities. A second major impetus for program growth was experienced when a General Accounting Office Report, "Improvements Needed in Program to Provide Alcohol Treatment Services to Veterans" was published in 1975, which criticized the "unavailability of VA alcohol treatment facilities in many large metropolitan areas," and recommended that the VA "incorporate essential supportive services, vocational rehabilitation, follow-on treatment, and family involvement into ATU programs." I believe the VA has been consistently responsive to Congressional guidance in this important treatment program.

In addressing the current and future projections of constrained fiscal resources, I am providing careful guardianship of these specialized treatment resources; a technical administrative directive is being prepared to emphasize the need for fullest possible assessment of alcohol-related clinical problems prior to hospitalization to assure that each such admission is appropriate and required. Those cases which can be treated effectively and safely in an outpatient or ambulatory modality will be admitted to that level of care whenever possible, for less expensive and less socially interruptive treatment. I am emphasizing that admission for detoxification treatment and specialized diagnostic studies and procedures which require hospitalization will be acceptable, but that discharge from hospital bed care to outpatient care should be accomplished as soon as clinically feasible in all cases, as a matter of professional accountability.

I will increase efforts at VA admissions offices to resolve questions of service-connection at the earliest possible moment in patient assessment, prior to hospitalization. Our current initiatives to improve ADP-facilitated information retrieval at individual field stations will materially assist in this endeavor.

I believe these efforts will provide for fully satisfactory utilization of resources during this period of austerity.

15. Please list the sources that are utilized to compile the requested information.

Answer: Questions 1 and 2:

Inpatient data : Patient Treatment File, FY 1980
Outpatient data: Outpatient Routing and Statistical Activity Records, FY 1980

Question 3:

a. Fourth Special Report to the U.S. Congress on Alcohol and Health, (U.S. Department of Health and Human Services: January 1981) pp. 3, 43-79

b. Alcoholism: A Practical Treatment Guide. Edited by Gitlow, S., and Peyser, H. Grune & Stratton, 1980 pp. 33-37

c. The Diagnosis and Treatment of Alcoholism Mendelson, J., and Mello, N. McGraw-Hill, 1979 pp. 3-16, 19-42

Question 4:

a. Inpatient data : Patient Treatment File, FY 1980

b. Outpatient data: Analysis not provided

Question 5:

a. ADPC: Automated Medical Information System (AMIS) 8DCI-10-260

b. Length of stay: Patient Treatment File, FY 1980

Questions 6 and 7:

Analysis not provided

Question 8:

a. Draft of Final Report: VA Contract Number V101(134)P-579 Kirschner Associates, Inc., September 1980, Highlights: pp. 6-10

b. Alcoholism and Treatment Armor, D., Polich, J., & Stambul, H. John Wiley & Sons, 1978, p. 92

Question 9:

a. 24-month followup:

Veterans Administration: Professional Services Letter IL 11-79-10, Subject: Report on the 24-Month Followup of VA-Provided Treatment of Alcohol Dependence, March 21, 1979, p. 11

b. 9-12 month followup:

Draft of Final Report:

VA Contract Number V101(134)P-579 Kirschner Associates, Inc., September 1980, Abstract, p. 2

c. NIAAA followup study:

Alcoholism and Treatment
Armor, D., Polich, J., & Stambul, H.
John Wiley & Son, 1978, p. 86

Question 10:

Veterans Administration, Department of Medicine and Surgery: Program Guide for Alcohol Dependence Treatment Program, M-2, Part X, G-12, August 24, 1977, Chapter 6: Treatment pp. 6-3 and 6-8

Question 11:

Veterans Administration, Department of Medicine and Surgery, Professional Services Letter IL 11-80-25, Subject: Specialized Medical Programs for Alcohol Dependence, July 30, 1980

Question 12:

a. Veterans Administration Reports Control Symbol (RCS) 14-4, Section III

b. Veterans Administration President's Budget: Medical and Construction Appropriation and Funds FY 1982, Volume II of V, January 1981, p. 6-43

Question 13:

a. Public Law 94-581, October 21, 1976. Veterans Omnibus Health Care Act of 1976

b. United States Code, Title 38, Section 612(f)

c. VA: DM&S Interim Issue 10-77-51

d. VA: DM&S Interim Issue 10-73-42

Question 14:

a. Mortality:

1. Fourth Special Report to the U.S. Congress on Alcohol and Health (Department of Health and Human Services, January 1981) pp. 3, 43, and 60

2. The Course of Alcoholism: Four Years After Treatment
Polich, J., Armor, D., & Braiker, H.
John Wiley & Sons, 1980, pp. 105-128

b. Biomedical Consequences:

1. Fourth Special Report to the U.S. Congress on Alcohol and Health (Department of Health and Human Services, January 1981) pp. 44-63

2. Veterans Administration: Patient Treatment File 812, FY 1980
Patient Treatment File 852, FY 1980
Patient Treatment File E01, RCS 10-255, FY 1980

Further information provided to the Committee by the VA, in the "1980 Supplement to Alcoholism and Problem Drinking 1970–1975—A Statistical Analysis of VA Hospital Patients (March 1982)", revealed that:

1. Discharges for a principal diagnosis of alcoholism increased from 8 percent in 1970 to 11 percent in 1980.
2. Defined alcoholics or problem drinkers among hospitalized veterans increased from 20 percent in 1970 to 26 percent in 1980.
3. Defined alcoholics or problem drinkers in the under 35 age group increased from 15 percent in 1970 to 35 percent in 1980.
4. Defined alcoholics or problem drinkers among hospitalized Vietnam-era veterans increased from 13 percent in 1970 to 38 percent in 1980.

According to the VA, in its 1981 and 1982 Annual Reports and in information provided to the Committee in April 1984, 100,757 inpatients and 425,295 outpatients were treated for alcoholism in VA health-care facilities in fiscal year 1981; 96,103 inpatients and 436,860 outpatients in fiscal year 1982; and 85,893 inpatients and 469,446 outpatients in fiscal year 1983.

The Committee remains deeply concerned about the large numbers of veterans affected by alcoholism and alcohol-related disorders. The Committee is especially concerned that the VA figures still take into account only four alcoholism-related diagnosis and do not include other alcohol-related disorders and, therefore, there are likely a higher number of veterans whose illnesses are complicated by drinking and whose alcoholism-disorder itself requires treatment who are not receiving appropriate treatment.

The Committee is also concerned that, although the reported numbers of inpatients are decreasing, the percentage of veterans reported as discharged for alcoholism or alcohol-related disorders has increased dramatically from 1970 to 1980. Particularly troublesome is the large number of veterans under age 35 and of Vietnam-era veterans in this latter category.

S. 2514 as introduced would have required the VA to prescribe regulations to establish maximum periods of treatment and rehabilitation for alcohol or drug abuse or dependence, disabilities, including detoxification, inpatient treatment, rehabilitation, and followup outpatient care. S. 2514 also would have required the VA to include regulations on the use of individualized treatment plans, and a minimum of 1 year of followup services (to determine the results of treatment and referral) to all veterans who had completed an inpatient treatment program for alcoholism. The goals of this provision were first, to standardize the VA's alcoholism treatment efforts by prescribing standards which mirrored general VA practices with respect to alcoholism treatment; second, to codify the VA's policy of emphasizing short term inpatient treatment and longev term outpatient care for alcohol treatment and rehabilitation; third, to promote the most appropriate and timely referral and treatment of the veterans through the various treatment phases; fourth, to increase the use of individualized treatment plans to take into account the veteran's specific needs, including care for other medical, psychological, and social problems; and fifth, to increase coordination of all phases of the veteran's treatment, including referral, use of community services, and other means of reintegration into the veteran's local community.

At the April 11 hearing, Dr. Custis expressed opposition to this provision in S. 2514 as introduced. In light of the VA's concerns, the Committee bill would require the VA to prescribe regulations setting forth general guidelines for VA medical facilities' treatment and rehabilitation programs for veterans with alcohol or drug abuse or dependence disabilities. The Committee believes that the proposed requirement for guidelines would provide the VA with complete discretion with respect to establishing medical policies but at the same time should produce more consistency and improvement in the efforts of the individual medical centers to treat the very large numbers of veterans with serious alcohol or drug disabilities.

Of particular concern to the Committee are veterans who may suffer from chronic alcoholism and who may be at greater risk for relapses. In a response to a question regarding these veterans following the April 11 hearing, the VA reported:

> Significant employment and income problems have been reported in over 35 percent of admissions. Significant family problems have been reported in over 40 percent of admissions. Significant social (other than family) problems have been reported in over 20 percent of admissions.

In response to an additional question about the VA's efforts to treat such veterans and how such efforts differ from VA treatment plans for other veterans with alcoholism, the VA provided the following information:

> Treatment program activities which address the special needs of relapse-prone veterans include the utilization of treatment plan contracts which are developed at the outset of treatment, the use of vocational rehabilitation programs, AA activities, family therapy, medical treatment of alcohol-related complications such as liver disease and malnutrition, and of outplacement into contracted community-based residential treatment and rehabilitation.
>
> These treatment plans differ from other alcoholism treatment plans in that they require more frequent use of post-detoxification outplacement into contracted community-based programs, or definitive medical treatment for the alcohol-related secondary diseases, and of job training and job placement services. The emphasis, in all cases, is on an individualized treatment plan.

The Committee strongly supports such efforts and expects that the regulations would include provisions encouraging such activities. In this regard, the Committee notes the testimony by Sandra K. Hill, Director, Alcoholism Treatment and Recovery Program, Suburban Hospital, and Chair, Board of Trustees, Baltimore Alcoholism Treatment Center (BATC), regarding the use by the BATC of a highly-structured chronic disease alcohol treatment model for persons who, because of additional medical, psychological, or social problems, are believed to be at a greater risk for an unsuccessful treatment outcome and have a greater chance of experiencing relapses.

Finally, the Committee is also interested in evaluations of VA alcohol treatment programs and their effectiveness. Testimony provided by Dr. Leonard Saxe of Boston University, and senior author of the Office of Technology Assessment study, "The Effectiveness and Costs of Alcoholism Treatment" (March 1983), concluded, first, that "any treatment for alcoholism is better than no treatment"; second, "an inpatient setting without an intensive community milieu and aggressive outpatient follow-up would be limited in value", and, third, "recent research and literature on alcoholism treatment has stressed the need to tailor treatment to individual needs". Dr. Saxe also recommended that the VA support research on its treatment efforts, use the results of research conducted elsewhere, and assess systematically the effects of changes in its approach to treatment. In response to a followup question, Dr. Saxe recommended that the VA reorient treatment services away from inpatient treatment to longer term outpatient care.

Testimony by The American Legion supported the establishment of centralized guidelines for all VA alcoholism treatment programs and clearly defined criteria for program and outcome evaluations:

> In the judgment of The American Legion, Congress does in fact have a role to play, not only in providing funding and authorizing staff in the treatment of substance abuse, but also in requiring the agency, at this point to pull together its diverse efforts to deal with this problem; to standardize, at least to a degree, those treatment components so far proven to be effective; and to develop a methodology to measure the effectiveness of the still expanding effort to deal with a serious national health problem that affects veterans as it does all elements of society.

Medical and Rehabilitative Devices

Section 4 of the Committee bill, which is derived with modifications from section 4 of S. 2514 as introduced, would provide the Administrator with specific authority—in order to assist in overcoming the handicap of deafness—to provide devices for the hearing impaired, including telecaptioning television decoders, to veterans who are profoundly deaf and who are entitled to disability compensation on account of a hearing impairment.

The VA issues over 1 million prosthetic and sensory aids to eligible veterans each year, including aids for the blind, artificial limbs, wheel chairs, automotive adaptive equipment, hearing dogs, TTY's (teletype machines which type out phone messages), automatic page turners, and electric beds. In 1983, the Committee learned that, as a result of the manner in which the VA determines eligibility for medical and rehabilitative devices issued under sections 601(6) and 617 of title 38, United States Code, veterans with service-connected hearing impairments were generally not eligible to receive television telecaptioning decoding devices.

A VA General Counsel opinion of July 9, 1980, specifically concluded that such devices, which the opinion noted are primarily "of psycho-social value" and "for the comfort and convenience of the veteran", could not be considered part of VA care or treatment under sections 601(6), 612 (a) or (f), or 617 of title 38, United States Code. Thus, unless an unusual case existed in which such a device might be medically necessary to keep a veteran's medical condition from deteriorating (the opinion discussed the hypothetical possibility of such a medical necessity being established in the case of a veteran with a sudden loss of hearing leading to "a morbid mental condition"), the opinion concluded that the VA did not generally have the authority to issue such a device to profoundly deaf veterans.

It is the Committee's intent in proposing this new authority under section 617 of title 38, under which the VA is authorized to issue invalid lifts and other devices to certain veterans, that profoundly deaf veterans in receipt of disability compensation for a hearing impairment be provided such medical and rehabilitative devices as will aid them in realizing their maximum rehabilitation and daily living potential within the constraints of their disabilities. The Committee believes that a TV decoder, just as a hearing dog and TTY, would serve to help a profoundly deaf veteran overcome his or her handicap in the same way as other devices, such as automatic page turners, assist quadriplegics.

In a response to a written question from Senator Simpson following the hearing, the DAV stated:

> The profoundly deaf veteran is totally precluded from all forms of everyday communication. A mobility impaired veteran may be precluded from ambulation without resort to a wheelchair, which acts as a substitute for a weakened, deformed or missing lower extremity(ies). Depending on the nature and degree of disability, mobility is hindered without a wheelchair, however, it is possible that other compensatory devices or aids may be utilized, i.e., walkers, crutches, canes, braces, etc. For the profoundly deaf, the single device available that would permit a veteran to achieve a higher level of rehabilitation or realize a direct and defined therapeutic value is a television telecaptioning decoder.

The Committee believes that TV decoders are only one of a variety of assistive devices which should be issued, when appropriate, to aid in meeting the medical and rehabilitative needs of profoundly deaf veterans with service-connected hearing impairment. Gwenyth R. Vaughn, Chief of Audiology and Speech Pathology Service at the Veterans' Administration Medical Center in Birmingham, Ala., provided the Committee with her views on the need for a balance of assistive devices, the need for which should be individually determined, in order to meet more adequately the needs of profoundly deaf veterans. Dr. Vaughn further stated that, when considering the use of a telecaptioning device, it is important, in her opinion, that at least three criteria should be utilized: (1) The veteran cannot benefit from the use of a hearing aid or an assistive listening device in order to view television; (2) the veteran is able to read and understand the captions; and (3) the veteran can benefit from a telecaptioning device as a part of his or her rehabilitation and personal and social well being.

In response to a written question from Senator Cranston, the VA indicated that the enactment of the provision in S. 2514 as introduced, which would have amended section 601(6) of title 38, United States Code, "could trigger reevaluation within DM&S of the circumstances under which such devices would be deemed medically necessary" under that authority. The Committee notes that the Committee bill would amend section 617, rather than section 601(6), and wishes to emphasize that, through this amendment, it does not intend to alter any current VA policy regarding the issuance of therapeutic medical and rehabilitative devices to eligible veterans. The Committee intends to provide a more balanced consistent approach to all veterans eligible for such devices.

The Committee notes that at the April 11 hearing, veterans service organizations indicated strong support for the objectives of this provision.

Post-Traumatic-Stress Disorder

Section 5 of the Committee bill, which is derived with modifications from section 5 of S. 2514 as introduced and section 12 of S. 2269 as amended, would require the VA to establish a Special Committee for Post-Traumatic-Stress Disorder (PTSD) to assist the VA's Chief Medical Director in developing policies, providing guidance, and coordinating the provision of services for the treatment of veterans with PTSD and to report to Congress on its efforts in this regard. This provision would also require the Chief Medical Director to establish and operate a National Center on PTSD to carry out research and training of health-care personnel in the diagnosis and treatment of PTSD and to coordinate the exchange of information among all VA and other Federal programs engaged in PTSD research and training activities and to report to Congress on its efforts in this regard.

Special Committee for PTSD

There has been growing sensitivity and awareness among mental health professionals, the VA, and the Congress of the prevalence of PTSD among veterans. In 1980, the American Psychiatric Association's Diagnostic and Statistical Manual (Third Edition) (DSM III) officially recognized PTSD and identified combat as a potential stressor.

Because this disorder is linked to military service, the Committee believes that the VA has a very strong obligation to be at the forefront of efforts to understand and treat it just as the agency has, in the past, taken leadership roles with respect to various physical disabilities such as spinal cord injuries and amputations, commonly resulting from military experiences.

The VA's readjustment counseling program—carried out at present through 136 Vet Centers—was established pursuant to section 103 of Public Law 96-22, the Veterans' Health Care Amendments of 1979. The Vet Center Program was extended by section 104 of Public Law 97-72, the Veterans' Health Care, Training, and Small Business Loan Act of 1981, and section 101 of Public Law 98-160, the Veterans' Health Care Amendments of 1983. Through the readjustment counseling Vet Center Program, the VA provides readjustment counseling and followup mental health services to eligible Vietnam-era veterans, including those suffering from PTSD.

To remedy an information gap concerning the prevalence and incidence and effects of PTSD among Vietnam-era veterans and in order to assist the VA in its efforts to provide assistance to these veterans, section 102 of Public Law 98-160 also required the VA to carry out a study on the issue of PTSD and other psychological readjustment problems and to report to Congress on its findings no later than October 1, 1986.

As John R. Smith, the Chairman of the VA Advisory Committee on Readjustment Problems for Vietnam Veterans, pointed out at the Committee's April 11 hearing, PTSD has been a recognized psychiatric disorder—through its inclusion in DSM III in 1980—for only a brief period of time. On this point, he stated:

> Although we had recognized it back in 1970, it was not until 1980 that we were able to finally achieve some formal recognition that this was a legitimate topic for inquiry and for research and should be addressed.

Because of the relatively recent acceptance by the medical community of this disorder, procedures for investigating, diagnosing, and treating it are not well established. The Committee believes that developing such procedures is an important challenge that should be met with the full energies and resources of the agency.

Although the VA has made substantial progress in the diagnosis and treatment of PTSD, the Committee believes that the agency should be doing more and doing it in a more coordinated fashion. Many of the VA's efforts to date—which have sprung largely from local initiatives—have been impressive. As a result of local medical center initiatives dating back to 1978, the VA has established 10 special inpatient units with 273 inpatient VA beds for treatment of Vietnam veterans with PTSD to provide inpatient treatment for veterans whose PTSD is too severe to be treated by Vet Centers or outpatient clinics.

An informal Committee survey found that most of the units ranged in size from 10 to 25 beds. Program eligibility varied and included Vietnam combat veterans, Vietnam veterans, veterans with PTSD, or combat veterans from other conflicts. Most veterans in these programs were in their mid-thirties and many had other diagnoses, including those associated with service-connected disabilities, substance abuse, and certain other mental health disorders. Treatment methods included the use of therapeutic community, individual, group, and family therapy, education and history of the Vietnam war, physical exercise, and other forms of treatment. The units reportedly each serve veterans from geographic areas that include from 1 to 10 states. The Committee also learned that VA health-care professionals associated with the units generally agreed that centralized involvement by the VA in the program is desirable to aid in the development of diagnostic and treatment methods, the education and training of VA health-care professionals, and the appropriate allocation of resources to the units. There was also agreement that treatment should be tailored to the needs of the veterans, which may vary by geographic area and other demographic factors as well as by combat experience. Finally, good clinical skills, adequate staffing, and adequate duration of treatment are also considered essential to the effective operation of such programs and to the successful outcome of treatment. Internal self-monitoring and program evaluation was recommended to ensure quality of care and appropriate use of resources.

A provision in S. 2514 as introduced would have required the VA to establish, in the Mental Health and Behavorial Sciences Service, the position of Associate Director for PTSD to establish policies and provide guidance for veterans with PTSD and provide for the education and training of VA health-care personnel concerning treatment for PTSD.

At the April 11 hearing, Dr. Donald Custis, then Chief Medical Director, expressed concern about the statutory establishment of such a position. In an effort to address this concern, the Committee bill requires instead that the VA establish a Special Committee for PTSD to advise the Chief Medical Director on a wide range of PTSD-related issues, including the activities of the National Center on PTSD (discussed below). Because of the complex and unique nature of PTSD and the need for close cooperation among several services in DM&S, the Committee believes that the views and expertise of the services and offices—Mental Health, Social Work, Readjustment Counseling, and the Office of Academic Affairs—referred to by Dr. Custis in his April 11 testimony should be coordinated in order to provide more effective assistance to the Chief Medical Director in determining VA policy regarding diagnosis and treatment for veterans with PTSD.

National Center on PTSD

Section 5(b) of the Committee bill, which is derived from section 12 of S. 2269 as amended would mandate that the VA establish a national center for research into PTSD and for training VA health-care personnel on appropriate treatment for veterans with this disorder. This center, which would be operated under the guidance of the Chief Medical Director, would also serve as a resource center on PTSD research and would seek to coordinate the exchange of information, both within and outside the VA, on PTSD research and training.

The Committee heard substantial testimony at its April 11 hearing favoring the establishment of a National Center on PTSD. For example, the VA, in the agency's written testimony stated:

> We consider the effective care and treatment of PTSD, as well as efforts to expand the understanding of health-care professionals regarding the diagnosis and treatment of the disorder, to be critically important aspects of the VA's responsibilities. Therefore, we support the objective of this provision.

In a similar vein, the Committee heard strong and convincing testimony from Jack Smith recommending—as he had 3 years earlier in an April 30, 1981, hearing before the Committee—the establishment of such a center. He stated:

> The creation, evaluation, documentation and dissemination of treatment alternatives for PTSD is badly needed.

> Documentation of the successes and their reasons, as well as of the shortcomings of the Vet Centers and existing PTSD programs is vital to the primary mission of the VA. Education and training of health care personnel in PTSD will be a major need for the next several years.

In addition, he pointed out: "The VA has the largest group of people undergoing the stress recovery process" and that "development and enhancement of PTSD response capability of the VA has important implications and possibilities for the nation at large. . . . A National Center for PTSD in the VA would generate benefits beyond the agency itself."

Other testimony expressed the sense that there is a need for such action. The American Legion stated that "there is a distinct need for research in this area, and a national center on PTSD would appear to provide an appropriate setting for such research to be accomplished." The Committee agrees with this view and believes that the National Center for PTSD would help focus the VA's efforts on this issue as well as provide an appropriate setting for research, education, and training.

The Committee also notes the Chief Medical Director's response to a question on the treatment of PTSD submitted by Chairman Simpson for the record following the April 11 hearing:

> I have indicated previously that there is "less than unanimity" among mental health professionals concerning the treatment of Post-traumatic Stress Disorder. This lack of agreement reflects the fact that active and healthy debate is going on in the mental health profession and among VA mental health professionals concerning the preferred approach for the treatment of Post-traumatic Stress Disorder. Some skilled mental health professionals believe that inpatient treatment is required for Post-traumatic Stress Disorder. Other equally skilled professionals believe that outpatient treatment is preferable. Parallel controversies exist throughout medicine concerning the best treatment for a wide variety of medical, surgical, and psychiatric conditions. From such controversy, comes progress through active exchange of ideas, research, and careful daily reexamination of clinical experience.

In light of the lack of consensus among mental health professionals within the VA and outside the VA, the Committee believes that the establishment of a National Center on PTSD would encourage the exchange of ideas and further the efforts to resolve some of the many questions concerning the diagnosis and treatment of PTSD. The Center is intended to promote the constructive development of new perspectives and information and assist the Chief Medical Director in formulating policy on the diagnosis and treatment of PTSD and assisting the VA's health-care professionals in providing appropriate care and treatment for veterans with PTSD.

The Committee notes the possibility that the VA will establish such a Center prior to the enactment of this legislation. The Committee has twice urged the VA in committee reports—S. Rept. No. 97-89 accompanying S. 921, 97th Cong., 1st Sess., p. 17, and S. Rept.

No. 98-145 accompanying S. 578, 98th Cong., 1st Sess., p. 33—to consider seriously the establishment of a national center of excellence for research on the diagnosis and treatment of PTSD and training of health-care personnel on such diagnosis and treatment. However, to date, although the then-Chief Medical Director, Dr. Donald L. Custis, expressed an interest in such a national center in correspondence with Senator Cranston, no firm commitments have been given regarding the establishment of a center. In this regard, during the Committee's April 11 hearing, Dr. Earl Brown, the VA's Associate Deputy Chief Medical Director indicated:

> Dr. Custis is encouraging the establishment of a new center in Cleveland, which will be tasked not only to provide treatment but also evaluation of various modes of treatment and to do research, in addition to disseminate what they learned through education through the ranks and any other educational process.

However, in an April 20 letter from Dr. Custis to Senator Cranston on this matter, Dr. Custis reported: "I have received a preliminary proposal for such a center from the Cleveland VAMC, and I fully expect to make a decision on its implementation within 60 days." Dr. Custis has since retired.

Although the Committee hopes that the VA will of its own accord establish a national PTSD center even prior to enactment of legislation containing this provision, the Committee believes, in view of prior experience in its twice having recommended such a center and in light of the unwillingness of DM&S thus far to commit any significant resources to this task, that a legislative mandate is necessary in order to ensure that the Center is established and that, thereafter, its operations are afforded a high priority.

Report on PTSD Efforts

A final provision in this section of the Committee bill would require the VA to report to the two Committees on Veterans' Affairs within 180 days of enactment on a number of matters related to PTSD, including an assessment on the agency's capability (particularly the capacity of its existing PTSD treatment units) to provide diagnosis and treatment to veterans with this disorder. The agency would be required to submit a report by February 1, 1986, and annually thereafter, updating the information in the preceding reports.

Programs for Terminally Ill Veterans

Section 6 of the Committee bill, which is derived with modifications from section 6 of S. 2514 as introduced, would require the VA to report to Congress on its programs to furnish palliative care (pain relief), supportive counseling, and other medical services to terminally ill veterans and supportive counseling to members of such veterans' families.

Methods of providing specific kinds of attention and care for terminally ill persons date back to the establishment of such programs by religious orders during the Middle Ages in Europe. One such method, hospice care, an organized, systematic, and multidisciplinary approach for providing palliative care and supportive services for patients who are terminally ill and assistance to their families in adjusting to the patient's illness and death, was first developed and utilized in the mid-1800's in France and Ireland. The modern hospice movement began in England with the founding of a freestanding hospice facility in London in 1967. The first formally organized hospice in the United States was founded in New Haven, Conn., in 1971.

The Federal Government's involvement in research and demonstration projects for hospice care dates back to 1973 when the National Cancer Institute funded a project to develop a national demonstration center for home care for terminally ill persons and their families. The Administration on Aging's research involving hospice demonstration projects, begun in 1979, found that a coordinated program of care could be proivided to terminally ill individuals in their own homes as a viable alternative to more traditional, institutional health-care programs.

The VA has initiated a number of programs for terminally ill veterans, generally focusing on those whose life expectancy is 6 months or less and for whom active treatment to achieve cure is considered no longer appropriate. In 1978, the Wadsworth VA Medical Center implemented a pilot palliative treatment program consisting of an 11-bed inpatient unit, a home care unit, and a consultation unit. Preliminary findings of a VA program evaluation of the Wadsworth unit indicated, first, that hospice patients and their families were significantly more satisfied with the interpersonal aspects of their care and in their participation in their care plan than control group patients were; and, second, that hospice patients were significantly less anxious than control group patients. No significant difference between the two groups was found on depression scores or in control of pain. The lack of a significant difference in pain control was believed to be a result of prior general dissemination to other hospital staff of information on hospice pain control techniques.

In May 1981, the VA conducted a survey of VA medical centers concerning care provided to terminally ill patients and their families. Results of the survey indicated that there were 10 facilities, in addition to Wadsworth, that had hospice-like programs—beds specifically designated for terminally ill patients—in operation and that five more such programs were being proposed. More than 90 VA medical centers stated they provided some type of counseling to terminally ill patients and their families. The majority of the counseling was provided by chaplains, followed (in order) by nurses, social workers, physicians, and psychologists.

In a June 1982, Chief Medical Director Letter (IL-82-23), guidance was provided to all VA medical facilities on palliative care. The letter stated the VA's commitment to the right of each patient to "as comfortable, tranquil and dignified a death as possible" and encouraged each facility to provide appropriate care to those patients for whom cure is no longer possible and death is predictable and imminent. The letter set forth concepts of a comprehensive palliative care program and recommended certain suitable models for palliative care programs.

The VA's Hospital Based Home Care (HBHC) program provides medical care to homebound and often bedbound patients. One of the primary functions of the HBHC program is to aid in providing medical care to terminally ill veterans, particularly those with cancer, to assist in home maintenance. Currently, there are 43 HBHC programs. The VA's fiscal year 1985 budget request as approved by the Committee would increase this number to 49.

The Committee supports the VA's efforts to provide alternative methods for caring for terminally ill patients and counseling for the patients' family members. The Committee further supports efforts to help patients remain free from pain and in the home environment as long as possible.

At the April 11 hearing on programs for the terminally ill, testimony presented by Dr. Martin Cohen, Chief of the Oncology Section at the VA Medical Center in Washington, D.C., indicated that the two main and equally important components of care for terminally ill patients are the relief of distressing symptoms and bereavement counseling. Sharron Dreyer, Assistant Administrator for Patient Care Services at the Hospice of Northern Virginia, stated that the ability of the patient to choose from a wide spectrum of health-care options, including hospice care, and the use of comprehensive and coordinated services are the most critical components of such care. However, Dr. Cohen also stated, "We still don't know the optional way to control pain, to relieve they myriad of distressful symptoms that terminal patients suffer, to improve a patient's functional status and mobility, to improve the quality of a patient's social interactions, to increase life-satisfaction or to relieve feelings of isolation and helplessness."

In the report that the Committee bill requires the VA to submit to Congress on programs of care for terminally ill veterans, the Committee expects the VA to assess the various kinds and models of such care already provided by VA-operated medical facilities and to consider what other methods of such care might be employed in VA medical centers. Thus assessment would include, but not be limited to, hospice care. The Committee is also interested in the most effective methods and levels of palliative care, supportive counseling, and other medical services, the most cost-effective methods, the optimal kinds and levels of staffing requirements needed to provide such care, counseling, and services, and the most appropriate mix of routine and ancillary services employed for each method.

The Committee recognizes that there is no consensus at this time among providers, researchers, and policymakers as to the cost-effectiveness of hospice care compared to traditional forms of care for terminally ill patients and believes that further research concerning this issue is necessary.

Automotive Adaptive Equipment

Section 7 of the Committee bill, which is derived with modifications from S. 2210 as introduced and a proposal by Senator Cranston, would provide that an eligible veteran may have VA-provided adaptive equipment on two vehicles that are available for his or her use and that the veteran shall not be entitled to automobile adaptive equipment for more than two vehicles at any one time and, unless, as a result of circumstances beyond the veteran's control, the veteran no longer has the use of one of these two vehicles, shall not be entitled to more than two such vehicles in any 4-year period.

Section 1902 of title 38, United States Code, currently authorizes the VA to provide certain severely disabled service-connected veterans with adaptive equipment necessary for them to operate safely an automobile or other conveyance. The VA, in accordance with August 14, 1973, and April 2, 1981, opinions of its General Counsel will not provide an adaptation for a veteran as long as he or she has the use of one VA-adapted vehicle. In addition, under current VA practice (DM&S Circular 1083-1, p. 14), adaptive equipment may be provided for up to three vehicles in 2 years.

Concerns have been raised over the past several years that this latter policy may lend itself to abuse by veterans who can obtain adaptive equipment on three vehicles within very short periods of time. The VA testified at a House Veterans' Affairs Committee hearing on June 15, 1981, that the agency supported a change in the automobile adaptive equipment program which would limit reimbursement for adaptations to one car within a 3-year period. A draft circular revising certain aspects of the program, including a limitation to reimbursement once in a 3-year period was prepared by the Prosthetic and Sensory Aids Service in 1983 and circulated in the agency and informally to veterans' organizations for comments. Subsequently, the revised circular was issued on May 25, 1983, but without the proposed "one-in-three-years" limit. S. 2210 as introduced reflected the policy in the draft revised circular.

According to a VA response to a followup hearing question from Senator Simpson on April 11, 1984, reviews of the automobile adaptive equipment program by the Office of Program Planning and Evaluation (OPPE) cited some instances "where veterans were provided replacement adaptive equipment more frequently than might have been essential." The response goes on to state:

> To resolve this suspected abuse, the (OPPE) report recommended prohibiting intrafamily transfer of vehicles and limiting reimbursement to one vehicle in three years. These recommendations were included in a "draft" cirular on the automobile adaptive equipment program, however, the one in three limitation was dropped because widespread abuse could not be substantiated and it was felt that this limitation was too restrictive.

With respect to the number of adapted vehicles allowed, the VA's formal views on S. 2210, submitted on May 7, 1984, reflected a change in agenty policy and supported a stricter limit to the frequency of adaptations. The VA noted in this regard, "We estimate that most of the eligible veterans do not seek reimbursement more than once in a three-year period, with the average utilization for the last three fiscal years being approximately one vehicle each 6.4 years."

At the Committee's April 11 hearing, the Committee received testimony from representatives of the Disabled American Veterans (DAV) and Paralyzed Veterans of America (PVA) that the current bar prohibiting a veteran from having the use of more than one VA-adapted vehicle at one time effectively precludes intrafamily transfer of title of the adapted vehicle and is a hardship to many of the severely disabled veterans eligible for this program. Such veterans, often amputees or spinal-cord injured, are extremely dependent on a vehicle for basic mobility outside the home. In cases where a veteran's adapted car is being repaired, the veteran becomes totally dependent on others for transporation. The PVA expressed concerns that a 1-in-3 limit might prove to be a hardship for some catastrophically disabled veterans.

The Committee believes that access to a backup means of transportation for a severely disabled veteran is very important. Therefore, the Committee bill provision would specifiy the maximum number of adaptations generally permissible within a period of time, two in 4 years, and permit a veteran to have the use of two VA-adapted vehicles at any one time. The Committee bill would further provide that, if the Administrator determines that, due to circumstances beyond the veteran's control, a veteran's specially-adapted vehicle is no longer available for the veteran's use, even though the veteran had been provided two adaptations within the past 4 years, the Administrator may provide adaptation for an additional vehicle as an exception to the 4-year-period rule (as long as the veteran has available no more than two vehicles at any one time). A veteran could, therefore, optain a second adapted vehicle within a 4-year period, but no further adaptation would generally be permitted until after that period had elapsed.

For example, if an eligible veteran who had not previously been provided adaptive equipment were provided equipment for an automobile on December 1, 1984, and for a second car on may 1, 1985, the veteran generally would not be eligible for adaptive equipment on another vehicle until December 1, 1988. If, however, one of the veteran's cars were so damaged in an accident on June 1, 1986, as to be unrepairable and the Administrator had decided to implement the discretionary authority to make exceptions in order to provide equipment in such a case, the veteran could be provided adaptive equipment for a third vehicle within the applicable 4-year period.

In the case of an individual who received automobile adaptive equiment from the VA for a vehicle after September 30, 1980, but before October 1, 1984, and has the equipped vehicle available for use on the date of enactment, the first 4-year period applicable in that individual's case would begin on the most recent date prior to october 1, 1984, on which he or she was provided equipment. For example, if an eligible person were provided with adaptive equipment for a car on January 1, 1981, and sold that car, and the VA provided adaptive equipment for that person's next vehicle on July 1, 1984, the first 4-year period applicable under section 1903(c) of title 38 as proposed to be amended would begin July 1, 1984. thus, that idividual would generally be entitled to adaptive equipment for no more than one more vehicle until July 1, 1988, at which time he or she would become entitled to adaptive equipment for another vehicle. Assuming that that person had available for use cars equipped at VA expense on January 1, 1987, and on July 1, 1988, he or she would then generally be ineligible for adaptive equipment until January 1, 1991.

The Committee's intent is to provide a more practical, workable program and one that is responsive to the needs of the seriously disabled service-connected veteran and that recognizes the possibility that a veteran's vehicle may, due to circumstances beyond the veteran's control, need to be replaced sooner than a "one-in-two" or "one-in-three" limit would permit. Thus, the Committee bill limits the number of adaptations while providing enough flexibility to allow for unique individual circumstances.

Definition of Vietnam Era

Section 8 of the Committee bill, which is derived from secton 2 of S. 2269, would modify the definition of the Vietnam era in section 101(29) of title 38, United States Code—the overall title 38 definition of the Vietnam era for the purpose of certain veterans' benefits—to include, in the case of those who seved in the Republic of Vietnam, the period begining of February 28, 1961, the date established in Public Law 89-257 for acceptance of foreign awards for service in Vietnam and used in a variety of other contexts (described below) as a starting date for the Vietnam conflict, and ending on May 7, 1975, the current law ending date for the Vietnam era.

The veterans benefits that individuals who served in Vietnam during the period from February 28, 1961, to August 4, 1964 (the current starting date for the Vietnam era) but not any other period of war might received include non-service-connected pension benefits if they also meet disability (or age), income, and net worth limitations; readjustment counseling; certain burial benefits; loan guaranty benefits in certain cases; and certain education, on-the-job training, or apprenticeship benefits for educationally disadvantaged, unskilled, or unemployed veterans.

As noted above, the starting date for the Vietnam era in current law is August 5, 1964. This date coincides with the Gulf of Tonkin incident unquestionably a watershed event in the history of U.S. involvement in Vietnam, and the resolution adopted by the Congress following that incident (the action leading to this Congressional action—an attack by North Vietnamese gunboats on two U.S. Navy destroyers—occurred on August 4; on August 5, President Johnson sent a message to the Congress regarding the matter and a joint resolution was introduced in Congress response thereto; on August 7, the Congress approved the so-called "Gulf of Tonkin Resolution" which was signed into law as Public Law 88-408 on August 11, 1964).

However, after careful consideration, the Committee determined that February 28, 1961, is a more appropriate starting date for the title 38 definition for those who served in Vietnam. This is the date set forth in Public Law 89-257 after which U.S. service personnel could accept awards from the Government of the Republic of Vietnam in connection with service in Vietnam. In the reports on the legislation—H.R. 3045 in the 89th Congress—that led to this public law, the Committees on Armed Services in both the House of Representatives and the Senate indicated that this date was selected because that was the approximate date on which American military advisers began to accompany "their Vietnamese counterparts on military operations" (H. Rept. No. 89-239, p. 2; S. Rept. No. 89-800, p. 2). This same date is used in other statutory contexts, including in section 112 of the Internal Revenue Code (relating to the treatment of income for tax purposes for members of Armed Forces serving in Vietnam in certain circumstances) and in section 239 (a) of the Immigration and Nationality Act (INA) (section 1440 of title 8, United States Code, relating to expedited naturalization based on wartime service). In addition, as noted in a letter from a Department of Defense representative to the Chairman of the House Committee on the Judiciary in connection with that committee's consideration in 1966 of the proposed amendment to the INA (which was adopted, as noted above), February 28, 1961, is the date selected by the Department of the Army for the award of the Combat Infantryman's Badge and the Combat Medical Badge.

In considering the issue of the appropriate starting date for the Vietnam era, the Committee recognized that there were a number of practical difficulties in setting a fixed date for a period of hostilities, such as were involved in Vietnam, where there was no one date when the United States' involvement changed in a dramatic fashion. The Committee believes that bringing the starting date of the Vietnam era for title 38 purposes into conformity with the above provisions for those who actually served in Vietnam, as is proposed in the Committee bill, is an appropriate action that will make access to veterans' benefits on the basis of service in Vietnam during wartime more consistent with other laws and regulations relating to such service.

The Committee notes that two other provisions in title 38 which define periods of war—section 101(6) (Spanish-American War) and section 101(7) (World War I)—are precedents for the approach adopted in the Committee bill for the definition of the Vietnam era. In both of those provisions, the period is longer for those who served in particular locations during specified periods.

Readjustment Counseling Eligibility Reports

Section 9 of the Committee bill would require two studies to be carried out relating to the VA's readjustment counseling program. This program was initially established pursuant to Public Law 96-22 in 1979. It continues to be a highly effective Government program for assisting those Vietnam-era veterans who have experienced readjustment difficulties since their service. Last year, in Public Law 98-160, the program as it presently operates, out of 135 Vet Centers, was given a 4-year extension until September 30, 1988.

Under current law, section 612A of title 38, eligibility for readjustment counseling is limited to veterans of the Vietnam era and, in certain circumstances, their family members. S. 2269 as introduced included provisions to expand the list of those eligible for such services as follows: First, to individuals who served during the Vietnam era but who are still on active duty—and thus not veterans under the applicable title 38, United States Code, definition; and, second, to both veterans and active-duty personnel who served in combat or combat-like situations (such as in Lebanon or Grenada) after May 7, 1975, the end of the Vietnam era.

Both during the Committee's April 11 hearing and subsequent thereto, various questions and concerns were raised about these proposed eligibility extensions. With reference to the two categories of active duty personnel—both those who served during the Vietnam era and those who have served since the Vietnam era in combat-like situations—the principal concerns related to, first, whether it was appropriate for the VA to assume responsibility for providing such services to individuals still under the auspices of the Department of Defense, and second, whether, if access to such services were provided to active duty personnel, they would be able to seek readjustment counseling assistance without in some way jeopardizing their military careers because of a negative perception that might be associated with receiving services that could be interpreted as psychiatric or psychological in nature. With reference to extending readjustment counseling eligibility to veterans of post-Vietnam-era service in combat situations, the principal concerns focused on the potential difficulty of determining to whom eligibility should be granted on this basis and on the question of equitable treatment for veterans from other periods of service who served in such situations, as well as the possible impact a new class of eligible veterans might have on the ability of Vet Center program to meet the needs of Vietnam-era veterans.

In light of these concerns, section 9 of the Committee bill, in lieu of the provisions to extend eligibility for readjustment counseling, contains provisions mandating that two reports on the issues involved be submitted to the Congress. The first such report would be undertaken as part of a previously mandated study on the future of the Vet Center program, a report on which is due by April 1, 1987. In this new report, the VA would be required to assess and describe the need for readjustment counseling among veterans and active-duty personnel who served in prior wars (with a particular emphasis on combat veterans), who are former prisoners of war, or who have served in post-Vietnam-era combat and combat-like situations. To the extent that the VA, as part of this assessment, identifies a need for readjustment counseling among any of these populations of veterans and active-duty personnel, the agency would be required to provide recommendations on how those needs might be met, taking into account the resources that would be necessary to meet any identified needs and the impact on Vietnam-era veterans of providing readjustment counseling assistance through the Vet Center program. In recognition of the fact that this assessment may be completed prior to the April 1, 1987, deadline for the previously mandated report (which is related to the completion date of a major study on the incidence of post-traumatic-stress disorder among Vietnam veterans), the bill would expressly authorize the VA to submit its report on this assessment at any time prior to April 1987.

With reference to the needs assessment with respect to those with service after the end of the Vietnam era (May 7, 1975), in the Committee's view, service in Beirut, Lebanon, during the period, September 29, 1982, through March 30, 1984, that the United States participated in the land-based multinational peacekeeping force and service as part of the United States' contingent that invaded Grenada in October 1983, for example, should receive particular emphasis in making this assessment.

The second report, which would be due to be submitted within 180 days after the date of the enactment of the Committee bill, would be a joint report from the Administrator and the Secretary of Defense. In this report, the Administrator and the Secretary would provide their recommendations on the appropriateness and desirability of extending eligibility for readjustment counseling to active-duty personnel who also served during the Vietnam era or since that time in combat-like situations such as Lebanon and Grenada. In making their recommendations on this issue, they would be required to take into account the impact of any expansion of eligibility on the VA's ability to provide readjustment counseling services to Vietnam-era veterans. In addition to the report on their general recommendations relating to eligibility for active-duty personnel, the Administrator and the Secretary also would be required to report on how VA readjustment counseling services might be provided if an expansion were authorized. Specifically, they would be required to report on whether VA and DOD would enter into agreements pursuant to which DOD would reimburse, in cash or in kind, the VA for such services and, if so, whether VA would be required to provide DOD with the names of the personnel provided counseling. With reference to the latter point, which bears on the issue, discussed during the Committee's April 11 hearing, of the possible disincentive, the report would have to include determinations with respect to whether requiring the VA to provide DOD names of persons counseled would discourage active-duty personnel from requesting counseling. Finally, this report would include determinations with respect to how, if an expansion of eligibility were to occur, VA and DOD would inform active-duty personnel about the availability of readjustment counseling from the VA.

The Committee expects these two reports to provide important new information to the Committee as it continues its oversight of the Vet Center program and considers legislative action relating to the future scope and mission of the program.

VA Securtity Service Officers

In recent years, the VA has experienced significant difficulties with providing security at numerous VA health-care facilities around the country, a situation that is attributed in large measure to problems the agency has had in attracting, and perhaps, more importantly, retaining security personnel. This problem has been particularly acute at some of the large VA medical centers located in urban areas. In a November 15, 1983, response to a letter from the Chairman concerning the recruitment and retention of VA security personnel, VA Administrator Harry Walters commented as follows on this problem:

> I have to state at the outset that security problems at VA medical facilities are serious enough to warrant my personal concern. Your references to a sharp rise in both property losses and weapons confiscated at medical centers are consistent with our experience. During the four-year

> period ending in 1982, both property losses and arrests at medical centers showed a significant and continuing annual increase, though not a "sharp rise." More disturbing is the growth over the same period in weapons confiscated at those facilities. In 1978, for example, there were 1,072 weapons confiscated in the medical centers. By 1982, the number had increased to 2,756. During the first 11 months of 1983, we confiscated 3,508 weapons. It is true that part of the rise in weapons being confiscated results from having more effective means of detecting them, such as metal detectors. But after taking our sophisticated detection equipment into account, it still appears that there has been a significant increase in the number of weapons being brought onto VA premises.

With reference to the relationship of the recruitment and retention problems to the significant security problems, Administrator Walters noted further:

> Turnover among law enforcement personnel is a matter for similar concern. From 29 percent in calendar year 1982, the turnover rate has so far this year moderated only insignificantly to 26 percent. We are impelled, moreover, to attribute some part of the unhealthy turnover statistics to discontent with pay rates. Nor is there any serious question that the turnover rates impede the training process by creating a backlog of untrained personnel.

In connection with the Committee's April 11 hearing at which the security issue was addressed, The American Legion submitted information which had been extracted from the visitation reports made by Legion National Field Staff members reporting on visits made to all 172 VA medical centers during the period June 1981 to March 1984. These extracts (table below), demonstrate in clear terms the scope and magnitude of the problem with security throughout the VA.

VA POLICE DATA EXTRACTED FROM THE AMERICAN LEGION NATIONAL FIELD STAFF VISITATION REPORTS

This report is for the period June 1981 to March 1984. Of the 172 VAMC's surveyed, the following medical centers reported serious problems.

Reasons for the high turnover rate of police officers and serious retention problems were continually presented to our field representatives.

Most noted reasons for the recruitment and retention problems are low salaries, inadequate or nonexistent upward mobility potential, and insufficient clothing allowances. Additionally, many facilities, currently at their assigned personnel ceilings for Security Service, are understaffed. Because of the aforementioned shortcomings, this service oftentimes acts as a steppingstone to other areas within the VAMC's.

REPORT ON VAMC POLICE SECURITY

Station	Visited	Problems
Tuskegee, AL	Mar. 29–Apr. 2, 1982	High turnover.
Fresno, CA	Apr. 4–8, 1983	Turnover significant.
Livermore, CA	Jan. 31–Feb. 4, 1983	High turnover.
Palo Alto, CA (2 Division)	Feb. 7–18, 1983	80-percent turnover.
San Diego, CA	May 17–21, 1982	High turnover.

REPORT ON VAMC POLICE SECURITY—Continued

Station	Visited	Problems
San Francisco, CA	Feb. 7-18, 1982	75-percent turnover.
Denver, CO	Nov. 1-5, 1982	Moderate to high turnover.
Fort Lyon, CO	Oct. 25-29, 1982	Retention poor.
Newington, CT	July 26-30, 1982	High turnover.
West Haven, CT	Aug. 2-6, 1982	Moderate turnover.
Wilmington, DE	July 11-15, 1983	Retention poor.
Washington, DC	Mar. 5, 1984	50-percent turnover, retention low, inadequate pay
Lake City, FL	Jan. 18-22, 1982	Poor retention.
Miami, FL	Aug. 24-28, 1981	High turnover.
Chicago (Lakeside), IL	Aug. 23-27, 1982	Moderate turnover.
Hines, IL	Apr. 5-8, 1982	40-percent turnover.
Des Moines, IA	Oct. 5-9, 1981	Turnover significant.
Iowa City, IA	Dec. 5-9, 1982	Turnover high.
Lexington, KY	Jan. 18-19, 1982	Turnover significant.
Alexandria, LA	Nov. 29-Dec. 3, 1982	Difficult to recruit and retain due to low pay and poor promotion opportunities.
New Orleans, LA	Dec. 6-10, 1982	Request for 20 additional FTE.
Togus, ME	Sept. 20-24, 1982	Staffing not sufficient. No promotion possibility.
Baltimore, MD	May 17-21, 1982	Approximately 40-percent turnover.
Fort Howard, MD	May 10-14, 1982	Turnover high due to poor pay. Downgraded 1979.
Perry Point, MD	Nov. 15-19, 1982	Staff retention affected by poor salary and increased responsibilities.
Bedford, MA	Sept. 7-10, 1982	Salaries not adequate. Turnover high.
Boston, MA	Sept. 13-17, 1982	Many vacancies. High crime plus low salaries does not attract quality people.
Northampton, MA	July 26-30, 1982	Recruitment is poor due to OPM registers and low salaries.
Brockton, MA	Feb. 6-17, 1984	Numerous complaints about salaries. Retention of young policemen very low.
Allen Park, MI	Apr. 25-29, 1983	Best policemen are lost due to poor salaries.
Ann Arbor, MI	May 2-6, 1983	Lack of adequate staff forces telephone operators to monitor police CCTV.
Battle Creek, MI	Oct. 24-28, 1983	12 policemen cover large psychiatric facility. Many incidents.
Iron Mountain, MI	Dec. 5-9, 1983	High turnover.
Saginaw, MI	Oct. 31-Nov. 4, 1983	100-percent turnover.
St. Cloud, MN	June 13-17, 1983	High turnover.
Kansas City, MO	Nov. 4-10, 1983	Turnover because lack of upper mobility.
St. Louis, MO (2 Division)	Oct. 12-22, 1983	High turnover. No promotion incentives. Inferior wages.
Fort Harrison, MT	Oct. 5-9, 1981	High turnover.
Grand Island, NE	Apr. 25-29, 1983	High turnover.
Omaha, NE	Sept. 9-23, 1983	Inadequate staff.
East Orange, NJ	Jan. 31-Feb. 4, 1983	Poor retention due to low pay.
Lyons, NJ	July 18-22, 1982	Difficult to recruit young policemen due to low salaries.
Bronx, NY	June 28-July 2, 1982	Difficult to recruit and retain. Low pay.
Brooklyn, NY	Mar. 14-25, 1983	Insufficient staff. Many incidents.
Canandigua, NY	Mar. 14-18, 1983	Pay less than nurse assistant.
New York, NY	Dec. 6-10, 1982	Very high turnover.
Northport, NY	Jan. 24-28, 1983	60-percent turnover.
Syracuse, NY	July 13-16, 1982	Serious retention problems.
Dallas, TX	Oct. 25-30, 1981	10 positions needed.
Antonio, TX	Oct. 31-Nov. 3, 1983	Above average turnover/salary problem.
Cleveland, OH	June 6-17, 1983	25-percent vacancies.
Dayton, OH	Jan. 30-Feb. 3, 1984	One rape, one murder during past 2 years.
Montrose, NY	Aug. 22-26, 1983	Inadequate coverage. Retention difficult due to low salaries. OPM registers are poor.
White City, OR	May 17-20, 1983	Moderate.

REPORT ON VAMC POLICE SECURITY—Continued

Station	Visited	Problems
Butler, PA	Jan. 31–Feb. 4, 1983	High turnover.
Pittsburgh, (PA) (Highland Dr)	Oct. 25–29, 1982	High turnover.
Providence, RI	Sept. 27–Oct. 1, 1982	60-percent turnover.
Big Spring, TX	Jan. 30–Feb. 3, 1984	High turnover.
Temple, TX	Oct. 31–Nov. 4, 1983	Inadequate coverage.
American Lake, WA	July 11–15, 1983	Poor retention.
Hampton, VA	Mar. 14–18, 1983	100-percent turnover. Crime problems.
Richmond, VA	Aug. 29–Sept. 2, 1983	Poor salaries. Registers' poor
Beckley, WV	Mar. 21–25, 1983	Resentment due to being downgraded.
Madison, WI	Sept. 19–23, 1983	Entire staff turnover in 1 year. Poor salaries.
Tomah, WI	Dec. 12–16, 1983	Difficulty recruiting candidates. Low salaries.
Sheridan, WY	Sept. 8–10, 1982	Section downgraded.
West Los Angeles, CA (Report prior to 7/15/81).	June 8–12, 1981	Inability to recruit. Low pay. 17 vacancies in a force of 32. Vandalism, theft.

In order to help address this problem, the Committee bill contains, in section 10, a number of provisions derived from section 6 of S. 2269 and Amendment No. 2850. These provisions would first, give the Administrator new authority, in section 4107 of title 38, United States Code, to modify rates of pay for security service officers; second, clarify the Administrator's authority to provide for security on VA property and to designate individuals to serve as VA security service officers; third, require the administrator to issue regulations relating to these employees, including their authority to make arrests, the content and duration of their training, limitations on the carrying and use of weapons, and other law enforcement matters; and, fourth, authorize the payment of a special clothing allowance for VA security service officers. Taken together, these provisions, which are described in more detail below, should help correct the problems the VA is facing in recruiting and retaining security personnel which, in turn should yield significant improvements in overall security.

Rates of Pay

The provisions in section 10 of the Committee bill relating to rates of pay would provide the Administrator with new authority to modify the rates of basic pay for security service officers in order (1) to provide rates of pay competitive with the rates paid by non-Federal employers in the same labor market to personnel in the same job category, (2) to achieve adequate staffing at particular facilities, or (3) to recruit persons with specialized skills. This authority can be exercised on a nationwide, local or other geographic basis, thereby giving the Administrator maximum flexibility to set rates of pay in response to local situations and conditions. The Administrator's use of this authority would be conditioned on a 90-day delay during which the Office of Personnel Management, as the President's delegee, could review the proposed increase and possibly disapprove it. If OPM were to disapprove a proposed increase, OPM would be required to submit a report to the Congress setting forth the basis for such action.

The VA acknowledged the need for new authority in its testimony at the April 11 hearing:

> The principal problem in the recruitment and retention of highly qualified personnel is our inability to pay competitive rates, particularly incertain geographic areas. This is evidenced by relatively high officer turnover in areas where competitive pay rates are generally higher than we were able to pay.

It is the Committee's expectation that this authority to modify rates of pay would be of significant benefit to the VA and should enable the agency to become competitive in selecting security personnel. Once the agency utilizes the proposed new authority to become competitive, the high turnover of security personnel should stop and this should in turn enable the agency to provide better security services at its many health care facilities.

Clarification of Authority to Provide Security

Although the VA has existing authority, in section 218 of title 38, United States Code, to provide for security on VA property not under the jurisdiction of the General Services Administration (this generally includes VA medical centers and VA cemeteries), there has been some confusion about various elements of this authority. In order to dispell any such confusion, the revised section 218 contained in section 10 of the Committee bill sets forth the Administrator's authority in clear terms and requires the administrator to prescribe regulations to provide for the maintenance of law and order on VA property. These regulations would be developed with the concurrence of the Attorney General in order to foster the result noted in the VA's testimony of achieving Government-wide coordination of law enforcement efforts.

Among the subject areas that the Administrator would be required to address in the regulations are rules of conduct on VA property and penalties of up to a $500 fine or 6 months in jail, for violating the rules; the authority of VA security service officers to enforce laws and regulations on VA property and to make arrests; the scope and duration of training required for VA security service officers; and rules limiting the carrying and use of weapons by such personnel.

With reference to the issue of the scope of training for VA security service officers, the Disabled American Veterans, in a response to a question posed by the Ranking Minority Member, following the Committee's April 11 hearing, suggested that "all VA police officers receive specialized training and handling of veterans in a hospital environment, especially with respect to the emotionally disturbed veteran". The Committee endorses this suggestion and notes that, under the provisions in the Committee bill, the regulations on the scope of training would have to include "a particular emphasis on dealing with situations involving patients".

On the issue of the use of weapons by VA security service officers, the VFW, in that organization's April 11 testimony, expressed the view that

> [W]e are opposed to the general carrying of firearms [by VA security service officers], and believe that their use should be restricted to extreme cases such as those dealing in drug arrests and the like.

The Committee believes that this position has considerable merit and urges the Administrator to pay particular attention to this question when preparing the mandated regulations.

Uniform Allownace

Other provisions of the Committee bill would authorize the Administrator to pay a uniform allowance to those VA security officers required to wear a uniform in the performance of official duties. These provisions provide for the payment of a $400 allowance at the time an individual is first employed as a VA security service officer so as to assist with the purchase of initial uniforms and a $200 allowance at the beginning of each fiscal year after the individual has completed 12 months with the VA to help these personnel replace and maintain their required uniforms. Thus, for example, in the case of an individual hired as a VA security officer on April 1, 1985, he or she could be paid an up-to-$400 allowance at that point and, beginning with October 1, 1986, could be paid an up-to-$200 allowance on or after each subsequent October 1.

In its April 11 testimony, the VA, in endorsing the uniform allowance provision, expressed the following points on the issue of a uniform allowance:

> One source of recruiting/retention problems is the low morale and financial hardship resulting from the fact that required uniforms cost much more than the authorized uniform allowance provides. Currently, VA police officers are allowed a flat $125 annually. . . . In our view, no one should have to suffer a financial disadvantage in order to work as a VA police officer, and the uniform allowance provisions would help prevent that.

The Committee strongly agrees with the final sentence and expects that the uniform allowance proposed in the Committee bill will help correct this situation.

Health-Care Staffing Report by the Comptroller General

Section 11 of the Committee bill, which is identical to sectio 7 of S. 2269 as introduced, would make a technical amendment to section 5010(a)(4)(C) of title 38, United States Code, so as to modify the due date of a recurring report by the Comptroller General mandated by section 5010(a)(4)(C). This report sets forth the Comptroller General's evaluation of action by the Director of the Office of Management and Budget to comply with other provisions of section 5010(a)(4) relating to personnel ceilings for the VA's Department of Medicine and Surgery.

Section 5010(a)(4) of title 38, enacted as part of Public Law 96–151, requires that, after the enactment of each law making appropriations to the VA (including regular and supplemental appropriations laws and continuing resolutions, whether or not the law contains appropriations for personnel purposes), the Director of the Office of Management and Budget provide the VA with the authority, together with the funds needed to carry out the authority, to employ not less than the number of employees for which the Congress has appropriated funds in three VA health-care accounts—

medical care, medical and prosthetic research, and medical administration and miscellaneous operating expenses—for the fiscal year involved.

That section further requires the Director of OMB, within specified time periods, to certify to the appropriate committees of the Congress and to the Comptroller General that the personnel ceilings and funding have been provided to the VA and requires the Comptroller General to report to the appropriate committees of the Congress on the Director's action of certification.

Report on Federal Government Responsibility to Individuals Who Served with Voluntary Civilian Organizations in Vietnam

Section 12 of the Committee bill, which is derived from section 9 of S. 2269, would require the Secretary of Defense, the Secretary of Health and Human Services, and the Administrator of Veterans' Affairs to submit to the Congress a joint report evaluating the question of United States Government responsibility, and alternative approaches, for providing Federal and other benefits, services, and assistance relating to disabilities that possibly result from certain aspects of service in Vietnam—such as exposure to Agent Orange or to particularly traumatic events—to individuals who were present there during the Vietnam-era as civilian employees of voluntary organizations.

Since questions relating to the health effects in veterans of exposure to Agenct Orange first came to national attention in 1977, the Committee has produced several major legislative initiatives and has engaged in rigorous oversight both of the VA's efforts to address veterans concerns on this issue as well as of the progress of the scientific studies relating to this matter. In this connection, the Committee has held five major hearings related to Agent Orange and has developed three major legislative initiatives on the issue: First, in 1979, mandating a large-scale epidemiological study of Vietnam veterans (section 307 of Public Law 96-151, later modified by Public Law 97-72); second, in 1981, providing authority for the VA to furnish health care for veterans exposed to Agent Orange (section 102 of Public Law 97-72); and, third, most recently with the Senate's passage on May 22, 1984, 95-0 of legislation (derived from S. 1651 and S. Res. 372), as an amendment to H.R. 1961, addressing the need for compensation standards.

In connection with these efforts relating to veterans who served in Vietnam, it has come to the Committee's attention that a number of the non-Federal civilians who served in Vietnam with voluntary organizations during the Vietnam era—such as the Red Cross and U.S.O.—and provided significant assistance to the U.S. Armed Forces share many of the veterans concerns about the effects of their service there. Several former employees of these organizations have contacted the Committee to make the point that they were potentially exposed to many of the same environmental situations and shared many of the experiences of the members of the Armed Forces. These individuals have noted that, because so much of the Federal Government's efforts to respond to concerns regarding the possible long term health effects of serving in Vietnam have involved an agency uniquely devoted to veterans (the

VA), they have been excluded from this process and any access to health care or compensation that it might yield.

In view of the contribution that these individuals provided to their country and their concerns about the long term health effects of their Vietnam service that may be related to actions by the Federal Government should evaluate the question of Federal responsibility and possible appropriate alternatives—Federal and non-Federal—for addressing such concerns.

The Committee notes that the report requirement in no way is intended to prejudge the question of Federal responsibility for assistance or to reflect a judgment by the Committee regarding the military or non-military status of any group of civilians who served in Vietnam for the purposes of receiving veterans benefits. A mechanism, the Department of Defense/Civilian Military Review Board, established pursuant to section 401 of Public Law 95-202, already exists to weigh evidence and pass judgment as to whether a particular civilian groups' service to the country during a period of war was such that it should be considered military service for the purpose of receiving veterans benefits. Section 12 of the Committee bill is not designed to circumvent or influence this separate avenue of redress. Rather, the Committee views the issue presently before it—the question of the extent to which the Federal Government may be responsible to these individuals and the need for an evaluation of alternatives for providing an avenue of redress for them if necessary—as entirely separate from the issue of veteran status.

Contract Care in Puerto Rico and the Virgin Islands

Section 13 of the Committee bill would extend by 1 year, until September 30, 1985, the VA's authority to contract for the furnishing in the Commonwealth of Puerto Rico and the Virgin Islands (and other territories and possessions of the United States) of hospital care for the care of non-service-connected disabilities and such medical services as will obviate the need for hospital admission for the care of such disabilities. This would be the fourth consecutive 1-year extension of this authority.

Background

Concerns about the provision of VA health care in Puerto Rico and the Virgin Islands were first raised by the Committee in 1977 in the Committee's report accompanying H.R. 5027 (S. Rept. No. 95-390, 95th Cong., 1st Sess., pp. 26-27). The General Accounting Office, in response to those concerns, studied this issue and, on March 30, 1978, issued a report on the VA's use of its then-existing contract authority to provide non-service-connected care in Puerto Rico and the Virgin Islands. This report, which is discussed in more detail in the Committee's report in 1978 accompanying H.R. 5029 (S. Rept. No. 95-825, 95th Cong., 2nd Sess., pp. 24-26), concluded that "a comprehensive assessment is needed of the health-care needs of veterans in Puerto Rico and the Virgin Islands". In response to this recommendation, the Congress, in Public Law 95-520, directed the VA to conduct a study on health care for veterans in Puerto Rico and the Virgin Islands, a report of which was submitted to the Congress on April 9, 1981. The report, which is discussed in more detail in committee reports in 1981 and 1982 accompanying S. 921 (S. Rept. No. 97-89, 97th Cong., 1st Sess., p. 8) and S. 2385 (S. Rept. No. 97-467, 97th Cong., 2d Sess., p. 19), identified the following major problems for the VA with regard to providing health care to veterans in Puerto Rico and the Virgin Islands: (1) Low quantity and quality of non-Veterans' Administration psychiatric care; (2) inadequate VA and non-Va ambulatory care facilities; (3) no VA nursing home beds and a near absence of non-VA nursing home beds; (4) inaccessibility of health care outside the VA; and (5) isolation of Virgin Islanders. The report listed four options for inpatient care, six options for outpatient care, and five options for nursing home care, including estimated construction costs and recurring operating costs, but did no recommend any specific option or options.

So that the Committee and the Congress could have sufficient time to obtain the Administration's views on, and to weigh these and various other options and, with assistance from the VA, select the most appropriate course for meeting the health-care needs of veterans in these areas, the contract non-service-connected care authority was extended by Public Law 97-72 until September 30, 1982. Because of the complex nature of the potential impact of the various options and the VA's unwillingness to select from among them and make recommendations to the Congress, such authority was again extended by Public Law 97-251, until September 30, 1983. In an explanatory statement which outlined the House and Senate compromise on legislation which became Public Law 97-251 (Congressional Record, August 18, 1982, p. S11064), the House and Senate Veterans' Affairs Committees noted that this was the second, consecutive short term extension of this authority and that it was likely that further extension would be required before a permanent approach to providing appropriate and cost-effective health care to veterans in those locations could be developed. In order to move towards such an approach as quickly as possible, the Committees considered it imperative that the VA take immediate steps to develop a comprehensive plan for providing such care and, to the extent that new construction would be involved, prepare the needed project proposals for inclusion in the President's fiscal year 1984 budget. In order to be able to evaluate the VA's proposal in this regard prior to the time that a further, short term extension of the fee-basis authority would have to be considered, the Committees directed in the explanatory statement that by December 1, 1982, the agency provide a specific, detailed proposal, including any construction project that the VA considered necessary, pertaining to health care for eligible veterans in Puerto Rico and the Virgin Islands and, most particularly, for meeting the health-care needs of those veterans in that population who have service-connected disabilities.

VA 1983 Options Reports

The VA report, "A Plan for the Delivery of Health Care to Veterans in Puerto Rico and the Virgin Islands", was submitted to the Veterans' Affairs Committees on January 20, 1983. The report addressed the problems which impeded veterans' access to health care in Puerto Rico and the Virgin Islands and provided a plan of action for hospital inpatient, outpatient, and nursing home programs, including three construction options. The report outlined certain guidelines to provide direction for the VA during preparation of specific recommendations on the health care of veterans in Puerto Rico and the Virgin Islands: (1) To the extent practical, all VA health-care services in Puerto Rico should be provided in VA-operated facilities; (2) the present utilization of health care provided under VA auspices is currently the best available indicator of need; (3) a veteran population of 130,000 in Puerto Rico, based on 1980 census information, will be used for planning; (4) the Medical District Initiated Program Planning (MEDIPP) process and methodologies should be adhered to as closely as possible; and (5) the potential for sharing arrangements for inpatient, outpatient, or nursing home care with any of the branches of the military is lacking. In addition, the report suggested that the VA realign existing space and construct new space in the VA Medical Center in San Juan to provide all inpatient bed needs, provide care at projected 1990 levels in the Mayaquez Clinic, place a VA-operated clinic in Ponce, expand the existing VAMC clinic, limit the fee program to the Virgin Islands, and construct a 120-bed nursing home facility.

Although, as noted above, the Veterans' Affairs Committees, in the explanatory statement on the House-Senate compromise of the bill enacted as Public Law 97-251 in 1982, specifically directed the VA to develop a comprehensive plan for providing health care for veterans in Puerto Rico and the Virgin Islands with needed projects prepared for inclusion in the President's fiscal year 1984 budget, the Administrator in the 1983 report issued disclaimers stating that the report "reflects a plan, but that the plan is not a recommendation and should not be construed as such"; and that the report did not "constitute a request for funding or for any other legislative action . . . [n]or does it necessarily represent the views of the agency or of the administration."

On March 9, 1983, in testimony before the Committee, the VA's Chief Medical Director, Dr. Donald L. Custis, stated:

> Regrettably, the complexity and timing of the Committee's request for this report did not permit the recommendations of this plan to be considered as part of the fiscal year 1984 budget process. Absent from the plan is the vital role of carefully considering the appropriate balance of the needs for our veterans in Puerto Rico and the Virgin Islands in relation to the needs of our veterans in all other parts of the United States.

In the light of the agency's failure to produce a comprehensive plan that it and the Administration supported, the contract authority was again extended, in Public Law 98-160, for one year until September 30, 1984, in order to ensure the continuity of medical care for certain veterans in Puerto Rico and the Virgin Islands. In order that previous efforts to address this problem would receive full consideration and to demonstrate the strong views of the Congress on this issue, Public Law 98-160 also specifically required that the VA submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives by December 1, 1983, a final report containing the plans of the Administrator, and the reasons therefor, for meeting the health-care needs of veterans in the Commonwealth of Puerto Rico and the Virgin Islands and that its plans take into account the recommendations of the VA's Office of Inspector General (IG) which are contained in that office's "Report of Special Audit, VA Medical and Regional Office Center (VAMROC), San Juan, Puerto Rico" (Report No. 3R2-A05-043), dated February 22, 1983.

In addition, it was specified that the plan be prepared in the context of achieving an appropriate balance of health-care needs for all veterans and that if the plan developed by the Administration and included in the required report included any construction projects, and if such construction project would require a prospectus under existing section 5004(b) of title 38, each construction project and its accompanying prospectus be included in such plan and report.

VA 1984 Report

The VA, in a report dated February 16, 1984, entitled "Report on Health Care Needs of Veterans in the Commonwealth of Puerto Rico and the Virgin Islands", submitted pursuant to section 107 of Public Law 98-160, stated that its review and final recommendation relating to those needs would be completed in the Spring of 1984, in the context of its review of the fiscal year 1986 Medical District Initiated Program Planning (MEDIPP) proposals for Medical District 3, which includes Puerto Rico. Thus, the 1984 report again failed to meet the Committee's need for information from the agency on the basis of which final action could be taken.

Committee Bill Provision and Related Action

Since the VA has not yet been able to arrive at a settled, overall approach to the future of its health-care program in Puerto Rico and the Virgin Islands despite repeated requests from the Committee and the Congress and two statutory mandates to develop a comprehensive plan for that purpose, the Committee reluctantly and with considerable frustration concludes that it is necessary to extend for 1 year, until September 38, 1985, the authority for contract care in order to continue to ensure continuity of care for certain veterans in Puerto Rico.

However, the importance attached by the Committee to the development by the VA of a comprehensive plan has been emphasized in recent actions by the Committee wherein the VA's request for the construction of a nursing home in Puerto Rico was deferred pending the Spring 1984 recommendations promised by the VA (S. Print 98-165, Budget Views and Estimates for Fiscal Year 1985, pp. 23-24, and Resolution of the Committee on Veterans' Affairs, U.S. Senate, adopted May 24, 1984). In taking this action to defer consideration of this project, the Committee expressed its belief that it would be unwise to proceed on a piecemeal basis with a single project in Puerto Rico with no notion of the priority that the VA would attach to that project in comparison with other possible projects or other funding needs, such as for mental health services, in Puerto Rico.

Payments for Therapeutic and Rehabilitation Activity

Background

Under section 618 of title 38, United States Code, the VA operated, in the Department of Medicine and Surgery, therapeutic and rehabilitation programs under which participants—VA patients, either inpatients, residents in domiciliary facilities, or outpatients, selected for such programs—perform services for which they receive a small payment. These programs are known commonly as incentive therapy (IT) and compensated work therapy (CWT) programs. Participants in IT programs are, according to the VA, in a recent white paper submitted to the Committee's Ranking Minority Member, "assigned duties within the treating VA Medical Center or Domiciliary as patient messengers, grounds workers, and building management assistants." IT participants are paid out of appropriated funds and receive hourly wages "ranging from a nominal amount to half the minimum wage". Patients in CWT programs, in contrast, "learn work habits and/or vocational skills" by working on projects under VA "contracts with private industry or other sources" and are paid wages under those contracts "commensurate with wages paid in the community for work of the same quality and quantity." According to the VA, both programs are designed to promote self-sufficiency in the participants by

> developing increased feelings of self-worth and socialization, prevention of depression and regressive behavior, and acquisition of prevocational skills in order to reduce dependency on long-term VA hospitalization and other support from Federal, State and local government sources.

In response to questions submitted by the Chairman following the Committee's April 11 hearing, the VA indicated that 85 VA facilities have IT programs and 40 facilities have CWT programs. In 1983, 30,347 veterans participated in IT programs and 7,250 veterans participated in CWT programs.

Last year, the VA's Inspector General conducted an audit (IG Audit Report No. 3R3-B02-066, March 31, 1983) that indicated that many veterans paricipating in these programs who were also in receipt of VA pension were not reporting income received from their participation in IT or CWT programs. In response to this report, the VA's Department of Medicine and Surgery instituted a program of income verification pursuant to which VA medical facilities, effective approximately January 1, 1984, began to inform appropriate regional offices of the Department of Veterans' Benefits of the amounts paid to veteran participants in these programs.

Proposed Legislation and Hearing

Because of numerous contacts—from staff of IT and CWT programs, other VA employees, participants in such programs, veterans' service organizations, and others—the Committee's Ranking Minority Member proposed legislation in Amendment No. 2850 to specify that payments to participants in these programs are not to be counted as income for purposes of VA pension.

During the Committee's April 11 hearing, this proposal received wide support. For example, R. Jack Powell, the Executive Director of the Paralyzed Veterans of America, expressed his organization's views as follows:

> PVA views enactment of this provision as a cost-effective measure. Successful completion of a rehabilitative program, which results in employment, not only removes the veteran from the pension program but also places the veteran in the position of being a contributing, tax paying citizen. This effort coupled with the other recommendations made by PVA over the past several years regarding the removal of the other work disincentives in the NSC pension program will greatly enhance the viability of the program and will assist many younger, catastrophically disabled NSC veterans in returning to employment and more productive lives.

Although the VA did not have an official position on this provision in its statement for the April 11 hearing, the agency's principal witness, than Chief Medical Director Dr. Donald L. Curtis, when asked for his personal, professional view on the result, in terms of the need for further hospital or medical care, in the case of individual veterans who are or should be in IT or CWT programs who refuse to complete such a course of therapy because of the pension disincentive, expressed the following personal view:

> It would be my personal opinion, Senator, that if this, what we know to be a very effective rehabilitation program were crippled by the disincentive that is implied here, that it would indeed result in a reversion of dependence on more medical care.

Dr. Curtis was also asked his personal, professional view on whether income received from participation in an IT or CWT program should be counted for pension purposes. Dr. Curtis replied:

> I think it is a significan disincentive of the purpose of the program, mainly, rehabilitation, were this to be counted as part of the pension program.

In order to gather further, first-hand information on this issue, Senator Cranston, on May 2, 1984, wrote to the Directors of two VA Medical Centers (Bedford, Mass., and Coatesville, Pa.) which has been identified by auditors from the General Accounting Office as facilities experiencing difficulties as a result of the new income verification program. Senator Cranston's letters and the replies from the two Directors are reprinted below.

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GEORGE J. MITCHELL, MAINE

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, D.C. 20510

May 2, 1984

Mr. Richard B. Nohe
Director
Veterans' Administration
  Medical Center
200 Springs Road
Bedford, Massachusetts 01730

Dear Mr. Nohe,

I understand that General Accounting Office auditors, during a recent site visit to the Bedford VAMC in connection with an ongoing GAO evaluation of VA mental health care programs, were informed of difficulties being experienced in the incentive and compensated work therapy (I and CWT) program there. As you know, a recent change was made in VA policy under the non-service-connected VA pension program whereby payments veterans receive for their work in these I and CWT programs are being counted as income to the veterans for the purpose of determining their entitlements to VA pension. This, in turn, has had the effect, for many of the veterans, of reducing their pension benefits by an amount equal to the I and CWT amounts they are receiving.

It is my understanding from the GAO auditors and others that at many facilities, including the Bedford VAMC, this VA pension policy change has had the entirely predictable result of discouraging participation in these therapy programs by VA patients in receipt of VA pension. I further understand from the GAO auditors that, at the Bedford VAMC, some veterans who were living in residential care homes while continuing their VA care on an outpatient basis along with their participation in these programs can no longer, because of the reductions in their total incomes resulting from the policy change, afford to live in residential care homes utilizing their own resources. I also understand from the auditors that, as a result, those veterans have had to be rehospitalized at the VAMC.

Because the Committee on May 9 is scheduled to consider legislation (section 11 of S. 2266 as amended) I have introduced to provide that payments to participants in I and CWT programs are not to be counted as income for the purposes of VA pension, I would appreciate receiving from you, at your earliest possible opportunity, a complete description of the situation that the GAO has outlined for me as well as any other information you can provide on the impact of the VA pension policy change on the I and CWT programs.

Thank you for your cooperation and assistance.

With best wishes,

Sincerely,

Alan Cranston

Alan Cranston
Ranking Minority Member

Edith Nourse Rogers Memorial Veterans Hospital
200 Springs Road
Bedford, MA 01730

Veterans Administration

MAY -4 REC'D

May 3, 1984

The Honorable Senator Alan Cranston
Ranking Minority Member
Committee on Veterans Affairs
United States Senate
Washington, D. C. 20510

Dear Senator Cranston:

Thank you for your interest concerning the recently imposed restriction on NSC pensions.

We would first like to point out that the reporting of income received by NSC veterans from Compensated Work and Incentive Therapy (CWT/IT) assignments was brought about by an Inspector General (IG) Survey. The IG pointed out that under current law such payments must be considered income for pension purposes. DM&S was therefore notified in January 1984 to report to DVB, the names of CWT/IT payment recipients and amount each received. This did not represent a policy change; rather, it became necessary for the VA to initiate a reporting and accounting procedure in order to comply with existing legislation.

Our initial report to DVB affected a total of 39 patients. Of that number, 19 patients (48%) terminated their participation in this program. Since that time, an additional 12 patients have left the program. All 31 patients cited this issue as their reason for leaving. An additional 30 patients have refused referral to this program because of the income restriction.

The loss of CWT/IT payments has made it necessary for our Social Work Service to renegotiate residential care rates for affected NSC pensioners in order to avoid eviction and eventual rehospitalization. The loss of income on the part of the residential care sponsors has, by necessity, been offset by a reduction in the number of outings for the patients, and in the variety and quality of food.

In short, patients who have left the CTW/IT program are functioning at a more marginal level as a result of their nonparticipation. This reporting requirement has created a significant disincentive for patients to take part in this therapeutically beneficial program. Furthermore, there is a notable increase in the level of anxiety of all CWT/IT participants. Many patients who are not presently affected by

In Reply Refer To:

this issue fear that they will be subject to reductions in income in future due to their participation in therapeutic work programs.

While we have no information which suggests that any patients have been rehospitalized as a direct result of this restriction, it is clear that its effect is unsettling to our patients, and could precipitate an exacerbation of psychiatric symptomatology. Based upon this, we can anticipate some rehospitalizations as an indirect result of this issue. In addition, this presents another obstacle to overcome in outplacing patients to supervised settings. The result will inevitably be increased hospital stays.

As you know, Social Security beneficiaries are not penalized for earning up to a certain amount. Upon reaching that amount, Social Security is reduced by $1.00 for every $2.00 earned. You may wish to consider establishing such limitations for CWT/IT participants.

In closing, those patients who can least afford a reduction in income are those affected by this legal requirement. The end result is that these patients are foregoing necessary work therapy to avoid a reduction in their pensions.

I trust this information is sufficient. If you have any further questions, please feel free to contact my office.

Sincerely,

R.E. Nohe

R. E. NOHE
Hospital Director

ALAN K. SIMPSON, WYO., CHAIRMAN
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United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, D.C. 20510

May 2, 1984

Mr. James L. G. Parsons II
Director
Veterans' Administration
  Medical Center
Black Horse Road
Coatesville, Pennsylvania 19320

Dear Mr. Parsons,

I understand that General Accounting Office auditors, during a recent site visit to the Coatesville VAMC in connection with an ongoing GAO evaluation of VA mental health care programs, were informed of difficulties being experienced in the incentive and compensated work therapy (I and CWT) program there. As you know, a recent change was made in VA policy under the non-service-connected VA pension program whereby payments veterans receive for their work in these I and CWT programs are being counted as income to the veterans for the purpose of determining their entitlements to VA pension. This, in turn, has had the effect, for many of the veterans, of reducing their pension benefits by an amount equal to the I and CWT amounts they are receiving.

It is my understanding from the GAO auditors and others that at many facilities, including the Coatesville VAMC, this VA pension policy change has had the entirely predictable result of discouraging participation in these therapy programs by VA patients in receipt of VA pension.

Because the Committee on May 9 is scheduled to consider legislation (section 11 of S. 2266 as amended) I have introduced to provide that payments to participants in I and CWT programs are not to be counted as income for the purposes of VA pension, I would appreciate receiving from you, at your earliest possible opportunity, a complete description of the situation that the GAO has outlined for me as well as any other information you can provide on the impact of the VA pension policy change on the I and CWT programs.

Thank you for your cooperation and assistance.

With best wishes,

Sincerely,

Alan Cranston

Alan Cranston
Ranking Minority Member

Medical Center Coatesville PA 19320

Veterans
Administration

May 4, 1984

In Reply Refer To: 542/11

Honorable Alan Cranston
United States Senate
Washington, D.C. 20510

Dear Senator Cranston:

In response to your letter of May 2, 1984, the following represents data provided to the General Accounting Office auditors during the course of their recent visit on February 9, 1984 to the Coatesville VA Medical Center. The figures are based on nonservice-connected veterans served by the Work Restoration (Incentive Therapy and Compensated Work Therapy) Programs in FY 1983.

Incentive Therapy-- treated 333 nonservice-connected veterans (58% of total veterans treated), paying out in hourly salary $69,998. Based on an average length of participation of 3.33 months, a veteran could expect to earn $63.00/month. If the same veteran were in receipt of a VA pension of $60.00/month, he could expect to have his pension reduced dollar for dollar based on the reported income from the Incentive Therapy Program, thereby earning $3.00 for a month's work.

Compensated Work Therapy -- treated 131 nonservice-connected veterans (85% of total veterans treated), paying out in piece rate wages $39,572. Based on an average length of participation of 4 months, a veteran could expect to earn $100.00/month. Applying the same principles as above, the veteran would earn $40.00/month for working in the Program.

These figures discourage veterans from participating in these important, vocationally oriented, therapeutic rehabilitation programs. Younger veterans have stated that they would not mind this temporary reduction in pension while participating in the program, but feel the adjudicative procedure necessary to adjust their VA pension after they leave the program is not worth the possible therapeutic gains.

As of January 1, 1984, we have been required to report the earnings of all nonservice-connected participants in Incentive and Compensated Work Therapies to the Adjudication Division of the VA Center in Philadelphia, Pa. All veterans in receipt of pension have received notices of pension reduction.

Honorable Alan Cranston
United States Senate
May 4, 1984

Many of our older outpatients are assigned to these therapies with the objective of maintaining their level of dignity and independence from full institutionalization. These veterans are unable to compete in an open job market, but with the VA pension supplemented by these monies earned "on the job," are able to live in boarding and foster homes.

When the VA pension is reduced by their earnings, these veterans no longer can afford carfare to the VA for therapy or even to pay for their meals when they come to the VA.

Current pension law (PL 95-588) is written to exclude income received from certain specific sources. It is the general feeling of the veterans at this Medical Center that the nominal amount that is earned in the Therapeutic Rehabilitation Programs should also be excluded as reportable income.

Lest anyone feel that the exclusion of monies earned during treatment in one of their Rehabilitation Programs represents a significant tax loophole, current law requires that IRS be notified of monies earned in excess of $600 during the calendar year. In 1983, of the 729 veterans participating in Work Restoration, only 50 (7%) earned in excess of $600.

I sincerely hope that your proposed legislation is enacted, and hope that the information provided will be of assistance to you in your endeavors.

Sincerely yours,

J.L.G. Parsons, II
Medical Center Director

Committee Bill Provisions

In light of the record before the Committee on this issue, the Committee determined that it was important to take steps with respect to the IT and CWT programs and, more specifically, with reference to the relationship between income earned by participants in these programs and their eligibility for VA pension. However, the Committee has taken short term action because of a lack of comprehensive information on, first, the extent to which participants in the program are in receipt of VA pension, second, the extent to which such participants are adversely affected by counting income earned by their participation in the program in determining annual income for pension purposes, and, third, the extent to which veterans, because of participation in the program, have gained employment and are no longer in receipt of a pension. In section 14 of the Committee bill, the VA would be required to conduct a 3-year demonstration project until December 31, 1987, during which income earned by participants for their participation in IT and CWT programs will not be counted in determining annual income for VA pension purposes (including for both the current law pension program and the so-called "old law" pension program). The Administrator would be required to submit a report by February 1, 1987, on the experience under this demonstration project during fiscal years 1985 and 1986. This report would be required to include information on the number of participants in IT and CWT programs who are in receipt of VA pensions, the costs of excluding IT and CWT payments from countable income for VA pension purposes, and the effect of excluding those payments on veterans' participation in the two rehabilitation programs. The Committee is also interested in information on the outcome of participation in the program, how this is measured, and the number of veterans with successful outcomes. The Committee expects that such information would also be included in the report.

The Committee bill also includes a provision which provides for retroactive payments to certain veterans who had their VA pensions reduced as a result of their participation in either IT or CWT programs during fiscal year 1984. The retroactive payment would be in an amount equal to the difference between the amount of pension the veteran would have received had the IT or CWT income not been counted for pension purposes and the amount of pension actually received during 1984. The purpose of providing for retroactive payment is to encourage veterans to continue in the program and not drop out (except for employment purposes) during the period between now and October 1, 1984 (which is the earliest date under section 401(b)(1) of the Congressional Budget Act that such an entitlement provision could be changed in legislation reported in the current calendar year).

Also, in light of a comment from the Disabled American Veterans in response to a question submitted by Senator Cranston after the Committee's April 11 hearing, this section of the Committee bill includes a provision specifying that neither a veteran's participation in an IT or CWT program nor the receipt of payments for such participation shall be considered as a basis for denying or discontinuing a veteran's receipt of 100-percent-rated compensation on the basis of unemployability. Although the Committee is not aware of any situation in which such a result has occurred, this provision is included in the Committee bill to preclude any such inappropriate result. The same result is also precluded as to the total disability status of a pension recipient.

The Committee intends to monitor closely the VA's efforts to carry out the demonstration project and to study carefully the mandated report (due by February 1, 1987) so as to evaluate what future action will be appropriate with respect to these two programs.

Health Care in Remote Areas

Section 15 of the Committee bill would provide for a study of and report on veterans who are eligible for health-care services from the Veterans' Administration and who reside in areas remote from existing VA medical care facilities and a subsequent report on a possible experimental program to furnish care to veterans in such areas. In carrying out the mandated study, the Administrator would be required to develop, to the maximum feasible extent, statistics on the number of eligible veterans who live at certain distances (i.e., less than 50 miles, 50–100, 100–200, and more than 200 miles) from VA medical facilities. In order to make such statistics useful for planning purposes, utilization measures for inpatient care/outpatient care and followup care (as defined in section 612(f)(1)(B) of title 38, United States Code) would be developed for each group of veterans as well as statistics regarding the age, service connection, and financial need of the veterans residing at the various distances from VA facilities.

Not later than January 1, 1986, the Administrator would be required to transmit to the Committees on Veterans' Affairs of the House of Representatives and Senate a full report on the statistics developed by the study. The report would include the Administrator's findings on the extent of the need for VA health-care services in remote areas, and the Administrator's findings and recommendations as to the advantages and disadvantages of alternative ways to furnish health-care services to eligible veterans in remote areas. Not later than July 1, 1986, the Administrator would be required to submit a subsequent report, in light of the first report, describing an experimental program that could be carried out in five remote areas to provide alternative methods for the VA to provide health-care services to eligible veterans in such areas and the Administrator's recommendations about the desirability of carrying out such a program or part thereof. This report would include locations, services, and projected costs.

The Committee held hearings July 13, 1983, on S. 523, a bill to establish an experimental program of diagnostic services in a single rural county of Maine. Testimony received at that hearing and information analyzed since then reinforce what is known about problems regarding access to health care in rural areas due to travel distances involved, adverse weather conditions, and capacity of health-care facilities to meet needs. In that context, issues surrounding eligibility for VA care were addressed, particularly in reference to problems in assessing the VA eligibility of rural veterans and clarifying that eligibility for VA care does not confer automatic entitlement to such care. In this regard, the Committee notes that the historic emphasis of the Congress as statutorily manifested in title 38, United States Code, has been on health care for veterans with service-connected disabilities and eligibility for certain other veterans "within the limits of Veterans' Administration facilities". The Committee has on several occasions encouraged the VA to consider creative solutions to improving access to VA health care for eligible veterans—such as through outreach activities or satellite efforts—through new allocations of beneficiary travel funds. In this regard, although the latest report regarding beneficiary travel, required by Public Law 98-160, was due on April 1, 1984, it has not yet been submitted.1

Underlying much of the discussion during and after the July 13, 1983, hearing was the lack of reliable data about the location, number and distribution throughout the United States of veterans with different eligibilities for VA health care. The Committee believes that the development of such statistics would help define the perceived rural veteran health-care problem. However, the Committee is also aware of the potential cost of an effort to describe statistically such a diverse population in such detail and has therefore specified in the bill that the statistics called for be developed only to the maximum feasible extent.

The Committee intends that the report required in section 15(b)(2) present the statistics developed by the study, the Administator's interpretation of those data with regard to the need to improve the VA's health-care capability in rural areas by eligibility category, and the advisability of meeting any need through contract or other arrangements.

COST ESTIMATE

In compliance with paragraph 11(a) rule XXVI, of the Standing Rules of the Senate, the Committee based on information supplied by the Congressional Budget Office, estimates that the costs resulting from the enactment of the Committee bill during the first 5 years following enactment would be $23.5 million in fiscal year 1985; $21.2 million in fiscal year 1986; $19.5 million in fiscal year 1987; $12.7 million in fiscal year 1988; and $13.4 million in fiscal year 1989. A detailed breakdown of the costs, as estimated by CBO, over the 5-year period follows:

CONGRESSIONAL BUDGET OFFICE

COST ESTIMATE

May 11, 1984

1. BILL NUMBER: S. 2514

2. BILL TITLE:

   Veterans Administration Health-Care Amendments of 1984.

3. BILL STATUS:

   As ordered reported by the Senate Committee on Veterans' Affairs, May 9, 1984.

4. BILL PURPOSE:

   To provide for coordinated referral services for veterans to community health and health-related services; to extend the authority of the Veterans Administration (VA) to provide contract care in halfway houses for the treatment of alcohol and drug abuse disorders; to authorize the VA to provide television telecaptioning decoders to veterans who are profoundly deaf and who are eligible for disability compensation; and for other purposes.

5. ESTIMATED COST TO THE FEDERAL GOVERNMENT:

(by fiscal year in millions of dollars)

	1985	1986	1987	1988	1989
Estimated Authorization Level	27.8	16.9	19.5	12.7	13.4
Estimated Outlays	23.5	21.2	19.5	12.7	13.4

The cost of this bill would fall in budget function 700.

Basis for Estimate:

The following section-by-section cost analysis only addresses those sections of the bill that could be expected to have a significant budgetary impact.

Section 2: This section would require the Administrator to establish an office in each VA health-care facility to coordinate and provide to veterans referral services to health and health-related services outside the VA.

(by fiscal year in millions of dollars)

	1985	1986	1987	1988	1989
Estimated Authorization Level	2.7	5.5	5.8	6.1	6.5
Estimated Outlays	2.6	5.6	5.8	6.1	6.5

Under this provision, a referral office would be established in each of the VA's 172 medical centers. It was assumed that offices would also be established in each of the 55 independent outpatient clinics and in the Central Office. It was further assumed that one full-time equivalent employee (FTEE) would be required, on the average, to staff each office, at an average grade level of GS-7. A staff of four FTEE was assumed for Central Office with an average grade of GS-9. A non-recurring cost of $1,000 per FTEE was assumed for furniture and equipment. Personnel costs were inflated in the outyears by the CBO's index for federal payraises plus one percent for merit increases.

Section 3: This section would extend for two years the authority of the VA to provide care under contract in halfway houses for the treatment of alcohol and drug-abuse disorders. The current authority expires at the end of fiscal year 1985.

(by fiscal year in millions of dollars)

	1985	1986	1987	1988	1989
Estimated Authorization Level	0.0	6.7	7.4	0.0	0.0
Estimated Outlays	0.0	6.7	7.4	0.0	0.0

In fiscal year 1984, $5.4 million was appropriated for this activity and an additional $5.4 million is requested for 1985. VA sources indicate that the current request will probably be insufficient for 1985; a total of $6.1 million is now expected to be needed. The above estimate assumes that there would be no further expansion in the use of this authority in 1986 and 1987. Thus, the outyear authorization levels were projected by increasing the amount needed in 1985 ($6.1 million) for anticipated inflation.

Section 4: This section would authorize the VA to provide television telecaptioning decoders to veterans who are eligible for disability compensation for total deafness.

According to the Veterans' Committee staff, television telecaptioning decoders cost about $200 each. Because the total number of veterans receiving disability compensation for total deafness is estimated at approximately 2,400, and because only a portion of the eligibles would be expected to apply in a given year, it is estimated that the cost of this provision would be less than $500,000 a year.

Section 5: This section would require the VA to establish a National Center on Post-Traumatic Stress Disorder (PTSD) to conduct research, train health-care personnel, and coordinate the exchange of information regarding PTSD.

(by fiscal year in millions of dollars)

	1985	1986	1987	1988	1989
Estimated Authorization Level	1.3	2.7	4.3	4.5	4.7
Estimated Outlays	1.3	2.7	4.3	4.5	4.7

Since the bill's language neither specifies an authorization level for the Center nor details the size and scope of its activities, the potential cost of the Center can only be approximated. It was assumed that the research function would be funded at about $2 million when the Center is fully operational. The education and training activities were assumed to be financed at $1 million, the exchange of information services at $0.5 million, and the Center's administration at about $0.2 million. It was also assumed that the Center would not be fully functioning until the latter half of 1986. Outyear costs were increased for anticipated inflation.

Section 8: This section would expand the definition of the Vietnam Era to include service in the Republic of South Vietnam between July 8, 1959 and August 4, 1964.

Certain veterans benefits, such as non-service-connected pensions and burial plot allowances, are restricted to veterans with service during a period of war. Psychological readjustment counseling is further limited to veterans with Vietnam Era service. Thus, by expanding the chronological definition of the Vietnam Era, this provision would grant entitlement for such benefits to veterans who served in Vietnam during this period but who have no other qualifying wartime service.

According to the VA and the Department of Defense, the number of veterans who would be affected by this provision cannot be precisely determined. The VA has estimated that between 15,000 and 20,000 persons served in Vietnam during this period, but the majority of these individuals are likely to have additional qualifying service either during the Korean Conflict or after August 4, 1964. Thus, it is expected that less than 10,000 veterans would be affected by this provision. With this relatively low number of new eligibles, the costs attributable to this provision should not be significant.

Section 10: This section would authorize the VA to increase the rates of basic pay for security service officers in VA health-care facilities when such increases are necessary in order to obtain or retain the services of such officers. The section would also increase the uniform clothing allowance payable to security service officers and would provide for a larger one-time allowance for newly employed officers.

(by fiscal year in millions of dollars)

	1985	1986	1987	1988	1989
Estimated Authorization Level	0.7	0.7	0.7	0.7	0.7
Estimated Outlays	0.7	0.7	0.7	0.7	0.7

According to the VA Security Service, approximately 1,950 security officers would be affected by this provision. The agency has estimated that the authority to increase basic pay would be utilized in 23 medical centers at a cost of about $400 thousand a year. This cost was assumed to increase in the outyears by the difference between the CBO assumption for federal payraises and the index of average hourly earnings.

The increased uniform allowance was estimated to cost $250 thousand per year on the assumption that all officers would receive the full allowance each year. According to VA information, there is an annual turnover of about 26 percent in security service officers. It was, therefore, estimated that around 500 newly hired officers would receive the one-time allowance of $400 each year.

Section 13: This section would extend for one year the authority of the VA to provide contract care in Puerto Rico and the Virgin Islands.

(by fiscal year in millions of dollars)

	1985	1986	1987	1988	1989
Estimated Authorization Level	21.3	0.0	0.0	0.0	0.0
Estimated Outlays	17.1	4.2	0.0	0.0	0.0

The estimate shown above represents those amounts requested by the VA for fiscal year 1985 for the provision of contract medical care in Puerto Rico and the Virgin Islands.

Section 14: This section would provide that certain income paid to veterans as participants in therapeutic or rehabilitative work programs should not be counted as income for the purposes of VA pension. The section further provides for a one-time payment to affected veterans equal to the amount of pension for which they would have been eligible had section 14 become effective on January 1, 1984.

(by fiscal year in millions of dollars)

	1985	1986	1987	1988	1989
Estimated Authorization Level	1.8	1.3	1.3	1.4	1.5
Estimated Outlays	1.8	1.3	1.3	1.4	1.5

Data is not available on which to determine which veterans participating in VA-sponsored work-rehabilitation programs are also receiving pensions. It was assumed, therefore, that one-half of the obligations of the Special Therapeutic and Rehabilitative Activities Fund have, prior to January 1984, been paid to veterans also receiving pensions. Since the non-VA income of pensioners offsets their pension payments dollar for dollar, the increase in pension costs under this provision would be equal to the total amount of income excluded from consideration.

6. ESTIMATED COST TO STATE AND LOCAL GOVERNMENTS:

The Congressional Budget Office has determined that the budgets of state and local governments would not be directly affected by the enactment of this bill.

7. ESTIMATE COMPARISON: None.

8. PREVIOUS CBO ESTIMATE: None.

9. ESTIMATE PREPARED BY: K.W. Shepherd (226-2820).

10. ESTIMATE APPROVED BY:

C.G. Nuckols
fr James L. Blum
Assistant Director
for Budget Analysis

REGULATORY IMPACT STATEMENT

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs has made an evaluation of the regulatory impact which would be incurred in carrying out the Committee bill. The results of that evaluation are described below.

A. *Estimate of the number of individuals and businesses who would be regulated and a determination of the groups and classes of such individuals and businesses:*

The enactment of the Committee bill would result in the regulation of individuals and businesses only under section 3, which would extend for 2 years the VA's authority to contract with halfway houses and other community-based facilities for the treatment and rehabilitation of veterans with alcohol or drug abuse or dependency disabilities. In such cases, the business concerned would be regulated to the extent that they must meet VA quality standards. It is not anticipated that the impact of any such regulations will be significant, however, as they would apply only to facilities which voluntarily seek VA referrals and would be similar to those already imposed on such entities by State and local licensing authorities. Based on fiscal year 1983, experience under current law, it is estimated that the number of businesses concerned will be 280.

B. *Determination of the economic impact of such regulations on individuals, consumers, and the businesses affected:*

As discussed above, the Committee does not anticipate that there will be any significant economic impact on individuals, consumers, or businesses as a result of the enactment of any of the provisions of the Committee bill.

C. *Determination of the impact on the personal privacy of the individual affected:*

The enactment of the bill would have no significant impact on the personal privacy of any persons.

D. *Determination of the amount of additional paperwork that will result from regulations to be promulgated under the bill:*

None of the provisions of the bill would entail regulations that would impose significant new paperwork requirements on individuals or businesses.

SECTION-BY-SECTION ANALYSIS OF S. 2514 AS REPORTED

Section 1

Subsection (a) of section 1 would provide that this measure may be cited as the "Veterans' Administration Health Care Amendments of 1984".

Subsection (b) of section 1 would provide that, except as otherwise provided, whenever in the Committee bill an amendment or repeal is expressed in terms of an amendment to, or repeal of a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

Section 2

Subsection (a) of section 2 would amend subchapter 1 of chapter 73 of title 38, United States Code, relating to the functions, organization, and administration of the Veterans' Administration's Department of Medicine and Surgery (DM&S), to add a new section, as follows:

New section 4120.—Coordination of referral assistance and services: Would require the Administrator of Veterans' Affairs—for the purpose of improving the provision of and enhancing the management of VA and non-VA health-care and health-related services to veterans eligible for VA care and with a special emphasis on veterans age 65 and over who are determined to need referral assistance—to designate one organizational unit in each VA health-care facility to coordinate the provision of referral assistance by the VA to eligible veterans and to facilitate and help coordinate the provision of non-VA care and related services. the Committee recognizes that the VA does not have the resources to meet all of the non-service-connected needs for health-care and related services of veterans whose eligibility is on a space-available basis and that in some cases both the VA and non-VA sources are engaged in providing services to the veteran.

The new section would also require the Administrator to carry out this section in a manner consistent with the national policy (enunciated in section 409(a) of Public Law 97-308) that the VA shall maintain a comprehensive, nationwide system of direct health-care services; with the mandate in present section 4101(a) of title 38 than DM&S operate a complete medical and hospital service; and with the Government's historic, firm commitment and moral obligation to provide care for service-connected disabled veterans. In addition, this provision would require the Administrator to carry out this section in conjunction with public and private agencies providing and coordinating services to elderly persons and with other pertinent agencies.

Subsection (b) of section 2 would amend the table of sections at the beginning of chapter 73 to reflect the addition of new section 4120 made by the amendment in subsection (a) of this section of the Committee bill.

Section 2—Costs: Enactment of section 2 is estimated to entail costs, in both budget authority and outlays, of $2.7 million in fiscal year 1985, $5.5 million in fiscal year 1986, $5.8 million in fiscal year 1987, $6.1 million in fiscal year 1988, and $6.5 million in fiscal year 1989.

Section 3

Clause (1) of subsection (a) of section 3 would amend subsection (a)(1) of present section 620A of title 38, relating to a 5-year pilot program for the provision of alcohol and drug treatment and rehabilitation through contracts with non-VA halfway house and other community-based programs, to delete the reference to the program as a "pilot" program. Under this amendment and the similar amendments proposed to be made by clause (2) of this subsection and subsection (c) of this section of the Committee bill, the program would no longer be regarded as a pilot program.

Clause (2) of subsection (a) of section 3 would amend subsection (e) of present section 620A to extent by 2 years, through September 30, 1987, the duration of the contract alcohol and drug program authorized by section 620A(a).

Clause (3) of subsection (a) of section 3 would amend subsection (f) of present section 620A to make a conforming change clarifying that the use of the term "pilot program" does not describe the program under section 620A after that section is amended by the Committee bill and to add a new subparagraph (2), as follows:

New paragraph (2) of subsection (f) of section 620A: Would require the Administrator to submit to the House and Senate Committees on Veterans's Affairs two reports on the Administrator's findings and recommendations pertaining to the operation of the contract alcohol and drug treatment program under section 620A(a). The first report, with respect to fiscal year 1985, would be due on March 1, 1986, and the second, with respect to fiscal year 1986, on March 1, 1987. The Administrator would be required to include in each report information for the fiscal year concerned regarding the average duration of veterans' participation in contract treatment and rehabilitation, the rates of successful rehabiltation, and any changes in average and maximum allowable charges per veteran under the contract program.

Clause (4) of subsection (a) of section 3 would further amend present section 620A by adding at the end a new subsection (h), as follows:

New subsection (h) of section 620A: Would require the Administrator, not later than 1 year after the date of enactment, to prescribe regulations providing guidelines for VA treatment and rehabilitation of veterans for alcohol or drug dependence or abuse. The guidelines would be required to include guidance on the duration of treatment and rehabilitation—taking into account duration of treatment and rehabiltation iin non-VA programs and identifying specifically duration in detoxification, inpatient-acute care, inpatient-rehabilitation care inpatient-extended care, outpatient care, and followup services—on the provision of referral assistance, and on the development, implementation, and monitoring of individual treatment plans and followup activities.

Subsection (b) of section 3 would require the Administrator to submit annually to the House and Senate Committees on Veterans' Affairs a report containing a comprehensive survey of VA-operated alcohol and drug programs during the fiscal year preceding the due date for the report—March 1 of each year beginning with March 1, 1985. The report would be required top rovide facility-specific information and national summaries regarding various specified matters relating to the operation of these programs. In addition, the Administrator would be required to include in the third report (due on March 1, 1987) information on the effectiveness of VA alcohol and drug treatment in light of the regulations required by subsection (h) of section 620A (as proposed to be added by subsection (a)(4) of this section of the Committee bill).

Subsection (c) of section 3 would amend the section heading of present 620A and the item relating to section 620A at the beginning of chapter 17 of title 38, to delete, consistent with the amendment proposed to be made by subsection (a)(1) of this section of the Committee bill, the words "pilot program".

Section 3—Costs: Enactment of section 3 is estimated to entail no costs in fiscal year 1984, $6.7 million in both budget authority and outlays in fiscal year 1985, $7.4 million in fiscal year 1986, and no costs in fiscal years 1988 and 1989.

Section 4

Would amend present section 617 of title 38, United States Code, relating to the furnishing of invalid lifts and other therapeutic or rehabilitative devices and certain other medical equipment and supplies to certain severely disabled veterans, to add a new subsection (b), as follows:

New subsection (b) of section 617: Would authorize the VA, in order to assist in overcoming the handicap of deafness, to provide assistive devices (including telecaptioning television decoders) to veterans who are profoundly deaf and are entitled to VA service-connected disability compensation on account of a service-connected hearing impairment, though not necessarily their profound deafness.

Section 4—Costs: Enactment of section 4 is estimated to entail costs of less than $500,000 per year.

Section 5

Would require the VA to take a number of steps designed to enhance its services for veterans with Post-Traumatic-Stess Disorder (PTSD).

Subsection (a) of section 5 would require the VA's Chief Medical Director, in order to enhance the VA's capability to diagnose and treat PTSD, to establish in the Department of Medicine and Surgery (DM&S) a Special Committee on PTSD and to appoint qualified DM&S employees to serve on the Special Committee. The Special Committee would be required to assess and carry out a continuing assessment of the VA's capacity to diagnose and treat eligible veterans who have PTSD and to advise the Chief Medical Director regarding the development of policies, the provision of guidance, and the coordination of services for the diagnosis and treatment of PTSD in various VA units and programs. The Special Committee would also be required to make recommendations to the Director for guidance regarding diagnostic and treatment methods and referral for and coordination of followup care. It would also make recommendations to the Director with respect to the evaluation of PTSD treatment programs, the conduct of research concerning PTSD diagnosis and treatment, special programs of education and training on PTSD for employees of DM&S and the VA's Department of Veterans' Benefits, the allocation of resources for all such activities, and any specific steps needed to improve diagnosis and treatment and to correct any deficiencies in the operations of inpatient PTSD units.

Subsection (b) of section 5 would require the Chief Medical Director to establish and operate a National Center on PTSD to carry out and promote research into, and the training of health-care and related personnel in, the diagnosis and treatment of veterans with PTSD. The Center would also serve as a resource center and would promote and seek to coordinate the exchange of information regarding all PTSD research and training activities carried out by the VA and other Federal and non-Federal entities.

Paragraph (1) of subsection (c) of section 5 would require the Administrator, nor later than 180 days after enactment, to submit to the House and Senate Committees on Veterans' Affairs a report on the implementation of subsections (a) and (b) of this section of the Committee bill. The Administrator would be required to include in the report a list of the members of the Special Committee on PTSD (established under subsection (a)); the Chief Medical Director's assessment, after consultation with the Special Committee, of the capability of the VA to meet the needs of Vietnam veterans, former POW's, and other eligible veterans for inpatient and outpatient PTSD diagnosis and treatment (both through PTSD inpatient treatment units and otherwise) as well as a description of the results of any evaluations made of PTSD inpatient treatment units in existence on the date of enactment; the Special Committee's plans for further assessments of the VA's capability to diagnose and treat veterans with PTSD; the recommendations made by the Special Committee to the Director; a description of the steps taken, plans made, and resources to be applied to implement subsections (a) and (b); and the Administrator's assessment of the VA's capacity to meet in all geographic areas of the United States the needs of eligible veterans for PTSD inpatient and outpatient diagnosis and treatment (both through PTSD inpatient units and otherwise) and any plans and timetable for increasing that capacity (including the costs of doing so).

Paragraph (2) of subsection (c) of section 5 would require the Administrator, not later than February 1, 1985, and on February 1 of each subsequent year to submit to the Veterans' Affairs Committees a report containing information updating the information in the most recent previous report or reports under this subsection of the Committee bill.

Section 5—Costs: The enactment of section 5 is estimated to entail costs of $1.3 million in both budget authority and outlays in fiscal year 1985; $[illegible].7 million in both budget authority and outlays in fiscal year 1986; $4.3 million in both budget authority and outlays in fiscal year 1987; $4.5 million in both budget authority and outlays in fiscal year 1988; and $4.7 million in both budget authority and outlays in fiscal year 1989.

Section 6

Subsection (a) of section 6 would require the Administrator, not later than September 30, 1985, to submit to the House and Senate Committees on Veterans' Affairs a report on VA programs to furnish palliative care, supportive counseling, and other medical services to terminally ill veterans and supportive counseling to their family members.

Subsection (b) of section 6 would require that the Administrator include in the report required by subsection (a) of this section of the Committee bill a review of VA policies and guidelines on the provision of palliative care, supportive counseling, and other medical services to terminally ill veterans and supportive counseling to members of their families; a review of the care furnished, including the treatment modalities used and services furnished by the VA; an analysis and a comparison of the care and counseling furnished with respect to terminally ill veterans in VA hospice care programs and in other VA programs, including a comparison of the routine and ancillary services, the duration of inpatient and outpatient treatment and hospital-based home care, and the cost of care and counseling furnished in the hospice and other programs; an explanation of how palliative care, supportive counseling, and other care to terminally ill veterans and supportive counseling to members of their families are or will be included in the overall VA plans for providing health care to older veterans in the future and the extent to which plans to furnish hospice care are included in those plans; a review of any steps taken to arrange for the exchange of information between VA facilities providing care for terminally ill patients with care provided to such patients by non-VA facilities; and any proposals of the Administrator for administrative or legislative action in this area.

Section 6—Costs: The enactment of section 6 is estimated to entail no significant cost.

Section 7

Subsection (a) of section 7 would amend subsection (c) of present section 1903, relating to various administrative aspects of the VA's program (under present section 1902) for providing certain service-connected disabled veterans and active-duty personnel with a one-time grant for an automobile or other conveyance and, within certain limitations, with necessary adaptive equipment for their automobiles or other conveyances, to modify a current restriction providing that an eligible person is not entitled to adaptive equipment for more than one vehicle at any one time. The Committee bill amendment would provide that an eligible person is generally entitled to adaptive equipment for no more than two vehicles in any 4-year period or at any one time. However, where the Administrator determines that, due to circumstances beyond the eligible person's control, one of the VA-equipped vehicles is no longer available for his or her use, the Administrator would be authorized, as a matter of discretion pursuant to regulations that the Administrator would be required to prescribe, to provide adaptive equipment for an additional vehicle during the 4-year period.

Paragraph (1) of subsection (b) of section 7 would provide that, except as provided in paragraph (2) of this subsection of the Committee bill, the amendment made by subsection (a) of this section of the Committee bill shall take effect on October 1, 1984.

Paragraph (2) of subsection (b) of section 7 would provide that, in the case of an individual who received automobile adaptive equipment from the VA for a vehicle after September 30, 1980, but before October 1, 1984, and has the equipped vehicle available for use on the date of enactment, the first 4-year period applicable in that individual's case would begin on the most recent date prior to October 1, 1984, on which he or she was provided equipment.

Section 7—Costs: The enactment of section 7 is estimated to entail no significant cost.

Section 8

Would amend present section 101(29) of title 38, defining for title 38 purposes the term "Vietnam era" as the period beginning on August 5, 1964, and ending on May 7, 1975, to provide that, in the cases of those who served in the Republic of Vietnam during the period beginning on February 21, 1961 (the date established in Public Law 89-257 for acceptance of foreign awards for service in Vietnam), and ending on August 4, 1964 (the day before the starting date of the era in current law) the Vietnam era also includes that period. The effect of this amendment would be to provide those who served in Vietnam during the 3 years and 5½ months prior to the current beginning date of the Vietnam era with general eligibility (subject to any applicable length of service requirement) for non-service-connected pension benefits under chapter 15 of title 38 (for those who also meet the disability (or age) requirement and income and net worth limitations); readjustment counseling under section 612A of title 38; certain burial benefits under section 902 (for those who are destitute and whose bodies are not claimed); extended eligibility for certain on-job training and education benefits under chapter 34 (for those who are educationally disadvantaged, unskilled, or unemployed); home-loan guaranty benefits under chapter 37 (in the cases of those who served more than 89 but less than 181 days); certain employment benefits under chapters 41 and 42; and eligibility under the Emergency Veterans' Job Training Act of 1983 (for those who are long term unemployed and apply for and enter programs of job training prior to September 30, 1984, and December 31, 1984, respectively).

Section 8—Costs: The enactment of section 8 is estimated to entail no significant costs.

Section 9

Subsection (a) of section 9 would amend subparagraph (B) of present section 612A(g)(2), relating to a VA report on the effectiveness and future structure of the VA's readjustment counseling program for Vietnam era veterans, due to be submitted to the House and Senate Committee on Veterans' Affairs by April 1, 1987, to provide that the Administrator include in that report the Administrator's assessments as to whether or not certain categories of persons not currently entitled to readjustment counseling need such counseling. Those categories comprise persons, either veterans or active-duty personnel, who served on active duty in World War II or the Korean conflict, with particular emphasis on those who engaged in combat; those who are former prisoners of war; and those who served after the end of the Vietnam era, with particular emphasis on those who served in areas in which the U.S. Armed Forces were engaged in armed conflict.

If the Administrator determines that there are needs among those individuals for readjustment counseling, the Administrator would be required also to include in that report the Administrator recommendations on the most desirable means by which these persons' needs should be met. In making that recommendation, the Administrator would be required to take into account the resources that would be required to meet those needs and, specifically, whether these individuals should be made eligible for VA readjustment counseling under section 612A and, if so, what effect that eligibility would have on the availability of VA readjustment counseling services for Vietnam-era veterans.

Finally, the amendment proposed to be made by this subsection of the Committee bill would specify that the Administrator may submit the above-described assessment and recommendations at any time prior to April 1, 1987.

Subsection (b) of section 9 would require the Administrator and the Secretary of Defense, not later than 180 days after the date of enactment, to submit to the appropriate committees of the Congress a joint report setting forth the Administrator's and the Secretary's recommendation—taking into account the extent of the availability of VA resources to provide readjustment counseling to Vietnam-era veterans—on the appropriateness and desirability of extending eligibility for readjustment counseling to active-duty personnel who served on active duty either during the Vietnam era, or subsequently, in an area of hostilities. ("Hostilities" would be defined for this purpose as a situation, as determined by the Administrator in consultation with the Secretary, in which members of the U.S. Armed Forces were subjected to armed conflict involving danger comparable to that to which Armed Forces members have been subjected in combat with the enemy during a period of war.) The Secretary and the Administrator would also be required to include in the joint report their determinations as to whether, if VA readjustment counseling eligibility were extended to either or both categories of personnel, the VA and Department of Defense would enter into an agreement or agreements pursuant to which the DOD would reimburse the VA for counseling services provided to active-duty personnel. If so, the Secretary and the Administrator would be required to provide their determinations as to whether or not reimbursement would be made without the necessity of the VA providing DOD with the names of the individuals counseled and, if reimbursement would not be made without the names being provided, their deteminations as to whether a requirement that the names be provided to DOD would discourage active-duty personnel from requesting counseling services. In addition, if counseling eligibility were extended, the report would be required to contain the Administrator's and the Secretary's determinations as to the manner and extent to which the VA and DOD would undertake to carry out outreach activities to inform the newly eligible persons about the availability of counseling and to contain any other information, determinations, or recommendations pertinent to the subject matter of the report that they consider appropriate.

Secton 9—Costs: The enactment of section 9 is estimated to entail no significant cost.

Secton 10

Would improve and clarify the VA's authority to provide security on VA property through a force of security service officers; authorize a special uniform allowance for uniformed VA security employees; and give the Administrator new authority to increase, for recruitment and retention purposes, the pay for VA security employees.

Subsection (a) of section 10 would amend present section 218 of title 38, relating to the Administrator's authority to prescribe rules and regulations regarding conduct on VA property and criminal penalties for violations and to enforce such rules and regulations and certain Federal laws on VA property, so as to clarify and modify those authorities. As amended, the catchline of section 218 would be "Security and law enforcement on property under the jurisdiction of the Veterans' Administration" and the text of section 218 would consist of revised subsections (a) and (b) of new subsections (c) and (d), as follows:

Revised subsection (a) of section 218: Would require the Administrator, with the concurrence of the Attorney General, to prescribe regulations to provide for the maintenance of law and order and the protection of persons and property on VA property (defined as land and buildings that are under VA jurisdiction and not under the control of the Administrator of General Services). The regulations would be required to prescribe, but would not need to be limited to, the following: Rules for conduct on VA property and the penalties for violations thereof—not to exceed a fine of $500 or imprisonment for 6 months (or such lesser amount or period as the Administrator prescribes in the regulations), or both; policies for the exercise by VA security service officers of the enforcement and arrest authorities that would be granted in subsection (b) of section 218 as proposed to be revised; the scope and duration of mandatory training for VA security officers, with particular emphasis on how to deal with situations involving patients; and rules limiting the carrying and use of weapons by VA security service officers. The rules regarding conduct, together with the penalities, would be required to be posted conspicuously on VA property.

Under current law, for the purpose of maintaining law and order and protecting persons and property on VA property—essentially the same purposes for which the Committee bill would require regulations to be prescribed—the Administrator is authorized, not mandated, to make rules and regulations for conduct on VA property, may authorize any VA officer or employee to make such rules and regulations, and is authorized to prescribe penalties, which may not exceed a fine of $50 or imprisonment for 30 days, or both. Thus, the effect of the Committee bill would be to make regulations mandatory, require that they be prescribed by the Administrator and have the concurrence of the Attorney General, increase the maximum penalties, and require that they encompass three additional subjects: Enforcement and arrests by VA security service officers, training of such officers, and rules limiting their carrying and use of weapons.

Revised subsection (b) of section 218: Would provide that the Administrator is authorized to designate VA employees as VA security service officers and that such officers shall enforce on VA property Federal laws and the regulations prescribed under subsection (a) of section 218 as proposed to be amended. These provisions are intended essentially to be streamlined, simplified versions of the current-law provisions (in present section 218(a) (1) and (2)) whereby VA "officers and employees" may be designated to act as "special policemen"; VA officers or employees who are authorized to perform investigative functions may be empowered to serve as "special investigators"; and such special investigators shall, while on VA property, have the power to enforce Federal laws for the protection of persons and property and the rules and regulations issued under subsection (a)(1) of present section 218.

With respect to the authority of VA security service officers to make arrests, revised subsection (b) would provide that, subject to restrictions imposed by regulations, such an officer may make an arrest, with or without a warrant, for any offense on VA property if the offense occurs in the officer's presence or if the officer has reasonable grounds to believe both that the offense constitutes a violation of any law of the United States or of the rules for conduct on VA property and that the person to be arrested has committed that offense.

In present section 218, the only express provision regarding arrests, a "special investigator" has authority to make an arrest with or without a warrant for an offense committed on VA property, if it is "committed in his presence" or if he has reasonable ground to believe that the offense is a Federal felony and that the person to be arrested is guilty of it. Thus, the Committee bill would clarify the arrest authority as including Federal offenses less than felonies and as generally being available for all VA security service officers, and would clarify the Administrator's authority to restrict the authority in the cases of individual officers or categories of officers. This provision is not intended to alter authority under current law to make arrests for violations of State law.

New subsection (c) of section 218: Would restate the Administrator's current-law authority (in present section 218(a)(2)) to use the facilities and services of Federal, State, and local law enforcement agencies when it is economical and in the public interest to do so and the Administrator has the agreement of the head of the agency concerned.

New subsection (d) of section 218: Would authorize the Administrator, notwithstanding subchapter I of chapter 59 of title 5, United States Code, setting forth Government-wide limitations on the provision of clothing allowances for uniformed security personnel, to pay VA security service officers who are required to wear a uniform while on duty allowances for the purchase of uniforms. These allowances would not be permitted to exceed a $400 allowance at the time the individual is first employed as a VA security service officer and a $200 annual allowance, with the first annual allowance being permitted to be paid as early as the first day of the first fiscal year that begins after the individual has completed 12 months of service and the first day of each subsequent fiscal year.

Paragraph (1) of subsection (b) of section 10 would provide that all of the provisions of present section 218 of title 38, other than clause (2) of subsection (a), relating to authority to designate VA officers and employees as special policemen, shall remain in effect until the Administrator prescribes the regulations required to be prescribed by subsection (a) of section 218 as proposed to be revised by subsection (a) of this section of the Committee bill. The Committee notes that this provision, leaving most of the provisions of present section 218 (and consequently most current regulations and other directives implementing that section) in effect, is intended to provide the Administrator with a reasonable period of time to develop the regulations for implementing section 218(a) as proposed to be revised and to enable the Administrator to avoid the possibility of a hiatus occurring with respect to various authorities of the Administrator to provide for the security of persons and property on the premises of VA facilities. However, the Committee expects the authority to prescribe the new regulations to be exercised promptly and intends to monitor the progress of the Administrator and the Attorney General in the development of the regulations.

Paragraph (2) of subsection (b) of section 10 would provide that the Administrator's authority under present section 218(a)(2) of title 38, to designate VA special policemen shall remain in effect until the Administrator exercises the authority proposed to be granted by revised subsection (b) of this section, to designate Va security service officers. This provision would make it possible for the Administrator to continue making designations under current law until such time as any administrative arrangements necessary for making designations under the new authority were completed. The Committee intends that implementation proceed on a timely basis.

Subsection (c) of section 10 would amend the table of sections at the beginning of present chapter 3 of title 38 to reflect the amendment proposed to be made to the catchline of present section 218 by subsection (a) of this section of the Committee bill.

Subsection (d) of section 10 would amend subsection (g) of present section 4107 of title 38, relating to the Administrator's authority, subject in some cases to Presidential veto, to increase certain VA employees' rates of basic pay in order to help overcome problems in the recruitment and retention of those employees, to add to the categories of VA employees for whom the Administrator may, subject to veto, increase the rates of basic pay for that purpose, employees providing security in buildings used by the VA to provide health care. This subsection of the Committee bill would also amend paragraphs (2)(A) and (4) of present section 4107(g) to delete the unnecessary use of the term "health-care" as a modifier of "personnel" and "facilities".

Section 10—Costs: The enactment of section 10 is estimated to entail costs of $700,000 in both budget authority and outlays in each of fiscal years 1985 through 1989.

Section 11

Would make a technical amendment in subparagraph (C) of present section 5010(a)(4) of title 38, relating to the requirement that the Comptroller General of the United States, not later than the 45th day after the enactment of each law making an appropriation to the VA, submit to the appropriate committees of the Congress a report on whether the Director of the Office of Management and Budget has complied with the requirements to provide the VA with the health-care personnel levels for which Congress has appropriated funds and to certify to the appropriate committees of the Congress the fact of having done so. Under present section 5010(a)(4), the Director of OMB generally has 30 days from the date of enactment of a VA appropriations law to provide that certification. However, where such a law is enacted more than 30 days prior to the beginning of the fiscal year involved, the certification is not due until the 10th day after the beginning of that fiscal year. In order to avoid a situation in which the Comptroller General's report on the Director's compliance is due before the Director's certification, the amendment would make the Comptroller General's report due by the 15th day after the Director's certification is due rather than 45 days after the appropriations law is enacted.

Section 11—Costs: The enactment of section 11 is estimated to entail no significant cost.

Section 12

Would require the Secretaries of Defense and of Health and Human Services and the Administrator to submit to the Congress a joint report on the question of U.S. Govenment responsibility for providing benefits and services to individuals who, during service in Vietnam with voluntary organizations that provided significant assistance to the U.S. Armed Forces, incurred disabilities that may be related to their service in Vietnam.

Paragraph (1) of subsection (a) of section 12 would state that the purpose of this section of the Committee bill is to provide a basis for the executive branch and the Congress to evaluate the question of U.S. Government responsibility, and alternative approaches, for providing individuals who served for a period of at least 30 days in the Republic of Vietnam during the Vietnam era as employees of voluntary organizations that provided significant assistance to the U.S. Armed Forces in Vietnam during the Vietnam era, with Federal and other benefits and services (including, but not limited to, health care and monetary compensation for disabilities which may be related to exposure to dioxin or be the result of traumatic events), either through the VA or otherwise, and for assisting those individuals in connection with disabilities they may have incurred as a result of their service in Vietnam.

Paragraph (2) of subsection (a) of section 12 would require the Administration and the Secretaries of Defense and of Health and Human Services, not later than 180 days after enactment, to submit to the appropriate committees of the Congress a joint report on the question of U.S. Government responsibility for establishing a program of benefits and services (as described in the above analysis of paragraph (1)) for those employees of voluntary organizations. The report would be required to set forth various alternative approaches, together with comments on the appropriateness and the advantages and disadvantages of each, for establishing such a program and any recommendations that the Administrator and the Secretaries have with respect to those alternative approaches.

Subsection (b) would provide that, for the purpose of this section, the terms "Armed Forces" and "Vietnam era" have the meanings set forth in section 101 (10) and (29), respectively, of title 38.

Section 12—Costs: The enactment of section 12 is estimated to entail no significant cost.

Section 13

Would amend present section 601(4)(C) of title 38, which defines "Veterans' Administration facilities" as including private facilities in certain circumstances and, by virtue of the use of that term in other, operative provisions of chapter 17, authorizes the furnishing of contract care (so-called "fee" care or "fee basis" care) under those circumstances, so as to extend for 1 year—from September 30, 1984, through September 30, 1985—the VA's authority to contract for the furnishing in Puerto Rico and the Virgin Islands (and other territories and possessions of the United States) of hospital care for the care of non-service-connected disabilities and such medical services as will obviate the need for hospital admission for the care of such disabilities.

Section 13—Costs: Enactment of section 13 is estimated to entail costs of $21.3 million in budget authority and $17.1 million in outlays in fiscal year 1985, $4.2 million in outlays only in fiscal year 1986, and no other costs in any other year. The Committee notes that the Administration-requested-budget for fiscal year 1985 includes funds in contemplation of this extension.

Section 14

Subsection (a) of section 14 would provide that, notwithstanding any other provision of law (and as limited by subsection (b) of this section to the period January 1, 1984, through fiscal year 1987), remuneration provided to a veteran or other participant in a therapeutic or rehabilitative activity carried out pursuant to present section 618 of title 38, relating to VA patients' work in certian VA therapeutic or rehabilitative work activities, shall not be counted as income for the purpose of payments of VA pension as defined in present section 101(15) of title 38. That definition includes all VA pension programs—both the current, so-called "improved" pension program, under chapter 15 of title 38, and the closed programs under which payments are made only to those who were "grandfathered" under a prior program, *i.e.,* were permitted (by section 9(b) of the Veterans' Pension Act of 1959 or section 306(a)(2) of the Veterans' and Survivors' Pension Improvement Act of 1978) to continue receiving the amount of pension they were receiving at the time that a new pension program went into effect. With certain specified exceptions, all income received by a VA pensioner under the current "improved" program reduces that individual's pension dollar for dollar. In the cases of "grandfathered" participants in the closed programs, their eligibility for continued payment depends on their total annual non-pension income remaining below specified amounts. Thus, in the cases of both improved pension recipients and those receiving pension under a grandfather provision, current law creates strong disincentives for participation in work therapy programs. Under the current program, since each dollar of remuneration for participation in a section 218 program reduces the individual's pension by $1, the individual receives no financial reward for his or her work; under the old program, an individual may be at risk of being permanently removed from the pension rolls if his or her remuneration under section 218, together with his or her other countable income, were to exceed the specified income limitation. Thus, the effect of the Committee bill would be to remove, for 3 fiscal years (plus, as noted in the discussion of subsection (b)(2) of this section, below, part of fiscal year 1984 in some cases), the disincentive under current law to participate in section 218 work-therapy programs.

Paragraph (1) of subsection (b) of section 14 would provide that subsection (a) of this section shall take effect on October 1, 1984, and shall cease to have effect on October 1, 1987, thus continuing in effect only through September 30, 1987.

Paragraph (2) of subsection (b) of section 14 would make it possible for individuals participating in section 618 threapeutic or rehabilitative activities between January 1, 1984, and the October 1, 1984, effective date to receive after October 1, 1984, the value of an income exclusion for remuneration they receive from their work in such activities. Thus, an individual who was a participant in such an activity on January 1, 1984—or became a participant on a date between January 1, 1984, and October 1, 1984—and who either participated continuously in the activity through September 30, 1984, or terminated participation earlier in order to enter into a higher-paying job would, as of October 1, 1984, be entitled to payment for the amount of pension that he or she would have been entitled to receive by virtue of the exclusion from countable income that subsection (a) of this section of the Committee bill would have created if subsection (a) had become effective as of January 1, 1984. For example, if an individual receiving VA pension under the current pension program entered a rehabilitative work-therapy program on March 1, 1984, remained in it continously through August 30, 1984, left the program to take a higher paying job, and had received average remuneration of $300 per month, or $1,800 for the 6 months he or she had been in the program, the amount of pension reduction that that individual would incur under current law by virtue of that $1,800 in income would be offset by the $1,800 in pension to which this provision would entitle him or her. Similarly, if that individual were a "grandfathered" pensioner and the $1,800 in income would cause him or her to be terminated, this provision would entitle him or her to any pension lost by virtue of the $1,800 in income having been counted. The Committee notes that, in such a case of a grandfathered pensioner being terminated because of the receipt of remuneration in a section 218 activity, he or she (if over age 65 or disabled) would be eligible for improved pension if his or her annual income did not exceed—or at any future time does not exceed—the applicable income standard under the improved program.

With respect to the requirement that the individual participate in a section 218 activity "continuously" from January 1, 1984—or a subsequent date on which the individual entered such a program prior to October 1, 1984—the Committee notes that it is not its intention that"continuously" be rigidly applied. Rather, the Committee intends that brief interruptions resulting from illness or injury or from disruptions in the section 218 activity not be construed as breaks in continuous participation as long as the individual's conduct under the circumstances is consistent with the intention to maintain his or her participation.

Subsection (c) of section 14 would require the Administrator, not later than October 1, 1987, to submit to the House and Senate Committees on Veterans' Affairs a report, with respect to fiscal years 1985 and 1986, on the implementation of subsections (a) and (b) of this section of the Committee bill. The report would be required to contain information regarding the numbers of individuals who participated in section 618 activities, the numbers of participants who are VA pensioners, the costs of excluding section 618 income from countable income for pension purposes, and the effect of the income exclusion on veterans' participation in such activities. The report would also include any recommendations that the Administrator has for legislative or administrative action in this area.

Subsection (d) of section 14 would amend present section 618 to add a new subsection (f), as follows:

New subsection (f) of section 618: Would provide that neither a veteran's participation in a section 618 activity nor the veteran's receipt of remuneration as a result of such participation may be considered as a basis for the denial or discontinuance of a total disability rating, for purposes of VA compensation or pension, based on the veteran's inability to secure or follow a substantially gainful occupation as a result of disability. Under the provisions in VA regulations (section 4.16 of title 38, Code of Federal Regulations) implementing the Administrator's authority, under present section 355 of title 38, to adopt and apply a schedule for rating disabilities under the service-connected disability compensation program, a total disability rating—often referred to as an "individual unemployability rating"—is to be granted, even though the so-called "schedular" rating is less than total, if the veteran is determined on a case-by-case basis to be unable to sucure or follow a substantially gainful occupation as a result of service-connected disabilities. VA regulations (section 4.17 of title 38, Code of Federal Regulations) implementing the VA's non-service-connected disability pension program contain provisions having the same effect with respect to total disability ratings for non-service-connected disabilities. Thus, the new subsection (f) would prohibit a veteran's participation in a section 618 program and remuneration therefor from being considered as a reason to deny or discontinue a total disability rating based on individual unemployability.

This new subsection would not cause the remuneration itself to be excluded from countable income, a subject dealth with by the provisions of subsection (a) of this section of the Committee bill.

Section 14—Costs: The enactment of section 14 is estimated to entail costs of $1.8 million in both budget authority and outlays in fiscal year 1985; $1.3 million in both budget authority and outlays in fiscal year 1986; $1.3 million in both budget authority and outlays in fiscal year 1987; $1.4 million in both budget authority and outlays in fiscal year 1988; and $1.5 million in both budget authority and outlays in fiscal year 1989.

Section 15

Would require a VA study of eligible veterans residing in areas remote from VA health-care facilities and such veterans' use of VA health care.

Subsection (a) of section 15 would express the following Congressional findings: That many veterans with service-connected disabilities and other veterans eligible for VA health care reside in areas of the United States that are geographically remote from VA health-care facilities; that, for many such veterans, VA health-care facilities are geographically inaccessible and, for many others, the inconvenience of travel to VA facilities discourages them from seeking health care from the VA; and that a study conducted by the Administrator of eligible veterans residing in remote areas and these veterans' utilization of VA health care would provide useful information on the feasibility and appropriateness of implementing alternative approaches to furnishing health care to these veterans.

Paragraph (1) of subsection (b) of section 15 would require the Administrator to carry out a study to develop information about veterans with VA health-care eligibility who reside in remote areas and to develop alternative approaches that could be adopted to furnish such veterans with VA care. In carrying out the study, the Administrator would be required to develop, to the maximum feasible extent, statistics on the numbers of eligible veterans who, during fiscal year 1985, reside within 50 miles of a VA medical facility, reside between 50 and 100 miles and between 100 and 200 miles from the nearest VA facility, and reside more than 200 miles away. The Administrator would also be required to develop, for each of the foregoing categories, statistics on the numbers of eligible veterans who, during that year, utilize VA medical facilities, receive VA inpatient care (including the typical lengths of stay of such veterans in VA facilities), receive VA outpatient care, or receive followup health-care services from VA facilities. The Administrator would be required to break down these statistics according to age, service connection, and financial need regarding the applicable veteran populations and to develop such further statistics and gather such additional information as the Administrator considers appropriate to carry out the study.

Paragraph (2) of subsection (b) of section 15 would require the Administrator, not later than January 1, 1986, to submit to the House and Senate Committees on Veterans' Affairs a full report on the study, including the following: The statistics and breakdowns developed and information gathered pursuant to paragraph (1) of this subsection; the Administrator's findings on the extent of the need for the VA to increase health-care services in remote areas; and the Administrator's findings and recommendations regarding the advantages and disadvantages of the VA contracting for and making other arrangements for furnishing health-care services to elibible veterans in remote areas.

Paragraph (3) of subsection (b) of section 15 would require the Administrator, not later than July 1, 1986, to submit to the House and Senate Committees on Veterans' Affairs a report describing an experimental program that could feasibly be carried out through projects in five remote areas—to be selected on the basis of the statistics, breakdowns, information, and findings included in the report submitted under paragraph (2) of this subsection—to demonstrate alternative approaches for the VA to furnish health-care services to eligible veterans in remote areas. The Administrator would be required to include in this report a description of the health-care services, and a detailed breakdown of the costs for them, that could be furnished to these veterans under an experimental program in each of the five areas, along with the Administrator's recommendations (and the reasons therefor) as to whether any such projects should be carried out and such recommendations for legislative or administrative action as the Administrator considers appropriate in light of the information contained in the report.

Section 15—Costs: The enactment of section 15 is estimated to entail no significant cost.

TABULATION OF VOTES CAST IN COMMITTEE

In compliance with paragraph 7 of rule XXVI of the Standing Rules of the Senate, the following is a tabulation of votes cast in person or proxy by members of the Committee on Veterans' Affairs at a May 9, 1984, meeting to consider S. 2514.

The committee agreed to report S. 2514, with an amendment in the nature of a substitute, favorably to the Senate by a 12-to-0 vote, as follows:

YEAS—12	NAYS—0
Alan Simpson	
Strom Thurmond	
Robert Stafford	
Frank Murkowski	
Arlen Specter	
Jeremiah Denton	
Rudy Boschwitz	
Alan Cranston	
Jennings Randolph	
Spark Matsunaga	
Dennis DeConcini	
George Mitchell	

AGENCY REPORTS

On May 7, 1984, the Veterans' Administration submitted to the Committee on Veterans' Affairs a report on S. 2210. In addition the VA submitted a report on S. 2278 (dated May 21, 1984). In lieu of reports on S. 2269 and S. 2514 from the Veterans' Adminstration the full statement of the then Chief Medical Director of the Veteran's Administration, appearing before the Committee on April 11, 1984, is included to express that agency's views on those measures. The agency reports and the statement follows:

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CHANGES IN EXISTING LAW MADE BY S. 2514 AS REPORTED

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38—UNITED STATES CODE

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PART I—GENERAL PROVISIONS

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CHAPTER 1—GENERAL

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§101. Definitions

For the purposes of this title—

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(29) The term "Vietnam era" means *(A)* the period beginning *on* August 5, 1964, and ending on May 7, [1975.] *1975, and (B) the period beginning on February 21, 1961, and ending on May 7, 1975, in the case of a veteran who served in the Republic of Vietnam during such period.*

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CHAPTER 3—VETERANS' ADMINISTRATION; OFFICERS AND EMPLOYEES

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SUBCHAPTER II—ADMINISTRATOR OF VETERANS' AFFAIRS

210. Appointment and general authority of Administrator; Deputy Administrator.
211. Decisions by Administrator; opinions of Attorney General.
212. Delegation of authority and assignment of duties.
213. Contracts and personal services.
214. Report to the Congress.
215. Publication of laws relating to veterans.
217. Studies of rehabilitation of disabled person.
218. [Standard of conduct and arrests for crimes at hospitals, domiciliaries, cemeteries, and other Veterans' Administration reservations.] *Security and law enforcement on property under the jurisdiction of the Veterans' Administration.*

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Subchapter II—Administrator of Veterans' Affairs

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§ 218. [Standards of conduct and arrests for crimes at hospitals, domiciliaries, cemeteries, and other Veterans' Administration reservations

[(a) For the purpose of maintaining law and order and of protecting persons and property on land (including cemeteries) and in buildings under the jurisdiction of the Veterans' Administration (and not under the control of the Administrator of General Services), the Administrator or any officer or employee of the Veterans' Administration duly authorized by him may—

[(1) make all needful rules and regulations for the governing of the property under his charge and control, and annex to such rules and regulations such reasonable penalties within the limits prescribed in subsection (b) of this section as will insure their enforcement. Such rules and regulations shall be posted in a conspicuous place on such property;

[(2) designate officers and employees of the Veterans' Administration to act as special policemen on such property and, if the Administrator deems it economical and in the public interest, with the concurrence of the head of the agency concerned, utilize the facilities and services of existing Federal law-enforcement agencies, and, with the consent of any State or local agency, utilize the facilities and services of such State or local law-enforcement agencies; and

[(3) empower officers or employees of the Veterans' Administration who have been duly authorized to perform investigative functions to act as special investigators and to carry firearms, whether on Federal property or in travel status. Such special investigators shall have, while on real property under the charge and control of the Veterans' Administration, the power to enforce Federal laws for the protection of persons and property and the power to enforce rules and regulations issued under subsection (a)(1) of this section. Any such special investigator may make an arrest with or without a warrant for any offense committed upon such property in his presence or if he has reasonable ground to believe (A) the offense constitutes a felony under the laws of the United States, and (B) that the person to be arrested is guilty of that offense.

[(b) Whoever shall violate any rule or regulation issued pursuant to subsection (a)(1) of this section shall be fined not more than $50 or imprisoned not more than thirty days, or both.]

Security and law enforcement on property under the jurisdiction of the Veterans' Administration

(a)(1) The Administrator, with the concurrence of the Attorney General, shall prescribe regulations to provide for the maintenance of law and order and the protection of persons and property on land and in buildings under the jurisdiction of the Veterans' Administration and not under the control of the Administrator of General Services (hereinafter in this section referred to as "Veterans' Administration property"). Such regulations shall prescribe, but need not be limited to—

(A) rules for conduct on Veterans' Administration property,

(B) the penalties, within the limits specified in paragraph (2) of this subsection, for violations of such rules,

(C) policies with respect to the exercise by Veterans' Administration security service officers of the enforcement and arrest authorities granted in subsection (b) of this section,

(D) the scope and duration of training that is required for Veterans' Administration security service officers, with particular emphasis on dealing with situations involving patients, and

(E) rules limiting the carrying and use of weapons by Veterans' Administration security service officers.

The rules prescribed under clause (A) of this paragraph, together with the penalties for violations thereof, shall be posted conspicuously on such property.

(2) Whoever violates any rule prescribed under paragraph (1)(A) of this subsection shall be fined not more than $500 or imprisoned not more than six months (or such lesser amount or period of time as the Administrator prescribes in the regulations prescribed under paragraph (1) of this subsection), or both.

(b) The Administrator may designate employees of the Veterans' Administration as Veterans' Administration security service officers. Such officers shall enforce Federal laws, and the rules prescribed under subsection (a)(1)(A) of this section, on Veterans' Administration property. Any Veterans' Administration security service officer, subject to any restrictions under the regulations prescribed under subsection (a) of this section, may make an arrest, with or without a warrant, for any offense on Veterans' Administration property if (1) such offense occurs in such officer's presence, or (2) such officer has reasonable grounds to believe (A) that the offense constitutes a violation of any law of the United States or of any rule prescribed under subsection (a)(1)(A) of this section, and (B) that the person to be arrested has committed that offense.

(c) With the agreement of the head of the agency concerned, the Administrator may use the facilities and services of Federal, State, and local law enforcement agencies when it is economical and in the public interest to do so.

(d)(1) Notwithstanding subchapter I of chapter 59 of title 5, the Administrator, pursuant to regulations which the Administrator shall prescribe consistent with paragraph (2) of this subsection, may pay allowances for the purchase of such uniforms to any Veterans' Administration security service officer who is required to wear a prescribed uniform in the performance of official duties.

(2) Allowances that the Administrator may pay under paragraph (1) of this subsection shall not exceed—

(A) at the time the individual is first employed as a Veterans' Administration security service officer, $400; and

(B) at the beginning of the first fiscal year that begins after the individual has completed 12 months of service as a Veterans' Administration security service officer and at the beginning of each subsequent fiscal year, $200.

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PART II—GENERAL BENEFITS

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CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

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SUBCHAPTER II—HOSPITAL, NURSING HOME OR DOMICILIARY CARE AND MEDICAL TREATMENT

610. Eligibility for hospital, nursing home and domiciliary care.
611. Care during examinations and in emergencies.
612. Eligibility for medical treatment.
612A. Eligibility for readjustment counseling and related mental health services.
613. Medical care for survivors and dependents of certain veterans.
614. Fitting and training in use of prosthetic appliances; seeing-eye dogs.
615. Tobacco for hospitalized veterans.
616. Hospital care by other agencies of the United States.
617. Invalid lifts and other devices.
618. Therapeutic and rehabilitative activities.
619. Repair or replacement of certain prosthetic and other appliances.
620. Transfers for nursing home care; adult day health care.
620A. Treatment and rehabilitation for alcohol or drug dependence or abuse disabilities[; pilot program].

* * * * * * *

Subchapter I—General

§ 601. Definitions

For the purposes of this chapter—

* * * * * * *

(4) The term "Veterans' Administration facilities" means—

(A) facilities over which the Administrator has direct juridiction;

(B) Government facilities for which the Administrator contracts; and

(C) private facilities for which the Administrator contracts when facilities described in clause (A) or (B) of this paragraph are not capable of furnishing economical care because of geographical inaccessiblity or of furnishing the care or services required in order to provide (i) hospital care or medical services to a veteran for the treatment of a service-connected disability or a disability for which a veteran was discharged or released from the active military, naval, or air service; (ii) medical services for the treatment of any disability of a veteran described in clause (1)(B) or (2) of the first sentence, or in the third sentence, of section 612(f) of this title or of a veteran described in section 612(g) of this title if the Administrator has determined, based on an examination by a physician employed by the Veterans' Administration (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veteran precludes appropriate treatment in facilities described in clauses (A) and (B) of this paragraph; (iii) hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving medical services in a facility described in clause (A) or (B) of this paragraph until such time as the veteran can be safely transferred to any such facility; (iv) hospital care for women veterans; (v) hospital care, or medical services that will obviate the need for hospital admission, for veterans in a State not contiguous to the forty-eight contiguous States, except that the annually determined hospital patient load and incidence of the provision of medical services to veterans hospitalized or treated at the expense of the Veterans' Administration in Government and private facilities in each such noncontiguous State shall be consistent with the patient load or incidence of the provision of medical services for veterans hospitalized or treated by the Veterans' Administration within the forty-eight contiguous States, but the authority of the Administrator under this subclause (except with respect to Alaska and Hawaii) shall expire on September 30, **[**1984,**]** *1985,* and until such date the Administrator may, if necessary to prevent hardship, waive the applicability to the Commonwealth of Puerto Rico and to the Virgin Islands of the restrictions in this subclause with respect to hospital patient loads and incidence of provision of medical services; or (vi) diagnostic services necessary for determination of eligibility for, or of the appropriate course of treatment in connection with, the provision of medical services at independent Veterans' Administration outpatient clinics to obviate the need for hospital admission.

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Subchapter II—Hospital, Nursing Home or Domiciliary Care and Medical Treatment

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§ 612A. Eligibility for readjustment counseling and related mental health services

(a) * * *

* * * * * * *

(g) * * *

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(2)(A) Not later than April 1, 1987, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the Administrator's evaluation of the effectiveness in helping to meet the readjustment needs of veterans who served on active duty during the Vietnam era of the readjustment counseling and mental health services provided pursuant to this section (and of outreach efforts with respect to such counseling and services). Such report shall give particular attention, in light of the results of the study required by section 102 of the Veterans' Health Care Amendments of 1983, to the provision of such counseling and services to veterans with post-traumatic stress disorder and to the diagnosis and treatment of such disorder.

(B) The report required by subparagraph (A) of this paragraph shall include—

(i) the opinion of the Administrator with respect to (I) the extent to which the readjustment needs of veterans who served on active duty during the Vietnam era remain unmet, and (II) the extent to which the provision of readjustment counseling services under this section in a program providing such services through facilities situated apart from Veterans' Administration health-care facilities is needed to meet such needs; **[**and**]**

(ii) in light of the opinion submitted pursuant to clause (i) of this subparagraph, such recommendations for amendments to paragraph (1) of this subsection and for other legislative and administrative action as the Administrator considers appropriate**[**.**]***; and*

(iii) assessments of whether or not individuals who—

(I) are veterans who served on active duty (aa) during World War II or the Korean conflict (with particular emphasis on those who engaged in combat with the enemy), (bb) during any period and who were prisoners of war, or (cc) after May 7, 1975 (with particular emphasis on those who served in areas during periods in which members of the Armed Forces in such areas were subjected to danger from armed conflict comparable to the danger to which members of the Armed Forces have been subjected in combat with the enemy during a periord of war), and

(II) members of the Armed Forces serving on active duty who (aa) served on active duty during World War II or the Korean conflict (with particular emphasis on those who engaged in combat with the enemy) or after May 7, 1975 (with particular emphasis on those who served in areas during periods described in division (I)(cc) of this clause), or (bb) were prisoners of war,

need readjustment counseling and, if so, the Administrator's recommendations on the most desirable means by which such needs should be met, taking into account the resources that would be required to meet such needs and specifically whether such persons should be made eligible for readjustment counseling under this section and, if so, what effect that eligibility would have on the availability of such services for Vietnam-era veterans.

The Administrator may submit the assessments and recommendations described in subclause (iii) at any time prior to April 1, 1987.

(3) Not later than July 1, 1987, the Administrator shall submit to such committees a report containing a description of the plans made and timetable for carrying out paragraph (1) of this subsection.

* * * * * * *

§ 617. Invalid lifts and other devices

(a) The Administrator may furnish an invalid lift, or any type of therapeutic or rehabilitative device, as well as other medical equipment and supplies (excluding medicines), if medically indicated, to

any veteran who is receiving (1) compensation under section 314(l)-(p) of this title (or the comparable rates provided pursuant to section 334 of this title), or (2) pension under chapter 15 of this title by reason of being in need of regular aid and attendance.

(b) In order to assist in overcoming the handicap of deafness, the Administrator may provide assistive devices, including telecaptioning television decoders, to veterans who are profoundly deaf and entitled to compensation on account of hearing impairment.

§ 618. Therapeutic and rehabilitation activities

(a) * * *

* * * * * * *

(e) The Administrator shall prescribe regulations to ensure that the priorities set forth in section 612(i) of this title shall be applied, insofar as practicable, to participation in therapeutic and rehabilitation activities carried out under this section.

(f) Neither a veteran's participation in an activity carried out under this section nor such veteran's receipt of remuneration as a result of such participation shall be considered as a basis for the denial or discontinuance of a total disability rating for purposes of compensation or pension based on the veteran's inability to secure or follow a substantially gainful occupation as a result of disability.

* * * * * * *

§ 620A. Treatment and rehabilitation for alcohol or drug dependence or abuse disabilities[; pilot program]

(a)(1) The Administrator, in furnishing hospital, nursing home, and domiciliary care and medical and rehabilitative services under this chapter, may conduct a [pilot] program under which the Administrator may contract for care and treatment and rehabilitative services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities for eligible veterans suffering from alcohol or drug dependence or abuse disabilities. Such [pilot] program shall be planned, designed, and conducted by the Chief Medical Director, with the approval of the Administrator, so as to demonstrate any medical advantages and cost effectiveness that may result from furnishing such care and services to veterans with such disabilities in contract facilities as authorized by this section, rather than in facilities over which the Administrator has direct jurisdiction.

* * * * * * *

(e) The Administrator may not furnish care and treatment and rehabilitative services under subsection (a) of this section after the last day of the [fifth] *seventh* fiscal year following the fiscal year in which the [pilot] program authorized by such subsection is initiated.

(f)(*1*) Not later than March 31, 1984, the Administrator shall report to the Committees on Veterans' Affairs of the Senate and House of Representatives on the findings and recommendations of the Administrator pertaining to the operation through September 30, 1983, of the pilot program authorized by this section *prior to the* *amendment of this section by the Veterans' Administration Health Care Amendments of 1984.*

(2) Not later than March 1, 1986, and March 1, 1987, the Administrator shall report to such committees on the findings and recommendations of the Administrator pertaining to the operation of the program authorized by subsection (a) during the preceding fiscal year and shall include in such report information for such year regarding average duration of participation of veterans, rates of successful rehabilitation, and any changes in average and maximum allowable charges per veteran under contracts entered into by the Veterans' Administration as part of such program.

(g) The authority of the Administrator to enter into contracts under this section shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

(h) Not later than 12 months after the date of the enactment of this subsection, the Administrator shall prescribe regulations to provide guidelines for the treatment and rehabilitation of veterans for alcohol or drug dependence or abuse disabilities under this chapter in facilities over which the Administrator has direct jurisdiction. Such guidelines shall include guidance—

(1) on the duration of such treatment and rehabilitation under this chapter, taking into account the duration of such treatment and rehabilitation in non-Veterans' Administration programs and identifying specifically duration in detoxification, inpatient-acute care, inpatient-rehabilitation and extended care, outpatient care, and followup services; and

(2) on the provision of referral assistance and the development, implementation, and monitoring of individual treatment plans and followup for veterans receiving such care and treatment.

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PART III—READJUSTMENT AND RELATED BENEFITS

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CHAPTER 39—AUTOMOBILES AND ADAPTIVE EQUIPMENT FOR CERTAIN DISABLED VETERANS AND MEMBERS OF THE ARMED FORCES

* * * * * * *

§ 1903. Limitations on assistance; special training courses

(a) * * *

* * * * * * *

(c)*(1)* An eligible person shall not be entitled to adaptive equipment under this chapter for more than [one automobile] *two automobiles* or other [conveyance] *conveyances (A)* at any one [time.] *time, or (B) except as provided in paragraph (2) of this subsection, in any four-year period.*

(2) If, in a case in which the limitation set forth in paragraph (1)(B) of this subsection precludes an eligible person from being enti-

tled to adaptive equipment, the Administrator determines that, due to circumstances beyond the control of the eligible person, one of the automobiles or other conveyances for which adaptive equipment was provided in the applicable four-year period is no longer available for the use of such person, the Administrator may, as a matter of discretion and pursuant to regulations which the Administrator shall prescribe, provide adaptive equipment for such person for an additional automobile or other conveyance during such period.

(d) Adaptive equipment shall not be provided under this chapter unless it conforms to minimum standards of safety and quality prescribed by the Administrator.

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PART V—BOARDS AND DEPARTMENTS

* * * * * * *

CHAPTER 73—DEPARTMENT OF MEDICINE AND SURGERY

SUBCHARTER I—ORGANIZATION; GENERAL

Sec.

4101. Functions of Department.
4102. Divisions of Department.
4103. Office of the Chief Medical Director.
4104. Additional appointments.
4105. Qualifications of appointees.
4106. Period of appointment; promotions.
4107. Grade and pay scales.
4108. Personnel administration.
4109. Retirement rights.
4110. Disciplinary boards.
4111. Appointment of additional employees.
4112. Special Medical Advisory Group and other advisory bodies.
4113. Travel expenses of employees.
4114. Temporary full-time, part-time, and without compensation appointments; residencies and internships.
4115. Regulations.
4116. Defense of certain malpractice and negligence suits.
4117. Contracts for scarce medical specialist services.
4118. Special pay for physicians and dentists.
4119. Relationship between this subchapter and other provisions of law.
4120. Coordination of referral assistance and services.

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Subchapter I—Organization General

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§ 4107. Grades and pay scales

(a) * * *

* * * * * * *

(g)(1) Notwithstanding any other provision of law but subject to paragraphs (2), (3), and (4) of this subsection, when the Administrator determines it to be necessary in order to obtain or retain the services—

(A) of individual employed in positions listed in paragraphs (1) and (3) of section 4104 of this title; **[or]**

(B) of health-care personnel who—

(i) are employed in the Department of Medicine and Surgery (other than administrative, clerical, and physical plant maintenance and protective services employees);

(ii) are paid under the General Schedule pursuant to section 5332 of title 5;

(iii) are determined by the Administrator to be providing either direct patient-care services or services incident to direct patient-care services; and

(iv) would not otherwise be available to provide medical care and treatment for [veterans,] *veterans; or*

(C) of employees providing security services, pursuant to section 218 of this title, in buildings under the jurisdiction of the Administrator (and not under the control of the Administrator of General Services) that are used for the purpose of providing health care,

the Administrator may increase the minimum, intermediate, or maximum rates of basic pay authorized under applicable statutes and regulations. Any increase in such rates of basic pay may be made on a nationwide, local, or other geographic basis, for one or more of the grades listed in the schedules in subsection (b)(1) of this section, for one or more of the health personnel fields within such grades, or for one or more of the grades of the General Schedule under section 5332 of such title.

(2) Increases in rates of basic pay may be made under paragraph (1) of this subsection only in order—

(A) to provide pay in an amount competitive with, but not exceeding, the amount of the same type of pay paid to the same category of [health-care] personnel at non-Federal [health-care] facilities in the same labor market;

(B) to achieve adequate staffing at particular facilities; or

(C) to recruit personnel with specialized skills, especially those with skills which are especially difficult or demanding.

(3) The amount of any increase under paragraph (1) of this subsection in the maximum rate for any grade may not (except in the case of nurse anesthetists and licensed physical therapists) exceed the amount by which the maximum for such grade (under applicable provisions of law other than this subsection) exceeds the minimum for such grade (under applicable provisions of law other than this subsection), and the maximum rate as so increased may not exceed the rate paid for individuals serving as Assistant Chief Medical Director.

(4) In the exercise of the authority provided in paragraph (1) of this subsection with respect to [health-care] personnel described in clause (B) *or (C)* of such paragraph to increase the rates of basic pay for any category of personnel not appointed under this subchapter, the Administrator shall, not less than ninety days prior to the effective date of a proposed increase, notify the President of the Administrator's intention to provide such an increase. If, prior to such effective date, the President disapproves such increase and provides the appropriate committees of the Congress with a written

statement of the President's reasons for such disapproval, such proposed increase shall not take effect.

* * * * * * *

§ 4119. Relationship between this subchapter and other provisions of law

Notwithstanding any other provision of law, no provision of title 5 or any other law pertaining to the civil service system which is inconsistent with any provision of this subchapter shall be considered to supersede, override, or otherwise modify such provision of this subchapter except to the extent that such provision of title 5 or of such other law specifically provides, by specific reference to a provision of this subchapter, for such provision to be superseded, overridden, or otherwise modified.

§ 4120. Coordination of referral assistance and services

In order to improve the provision, and enhance the management, of health-care and health-related services by the Veterans' Administration and other sources to veterans who are eligible for care under chapter 17 of this title, with a special emphasis on veterans who are 65 years of age or older, and who are determined by the Administrator to be in need of assistance under this section, the Administrator shall designate one organizational unit in each Veterans' Administration health-care facility for the purpose of coordinating the provision of referral assistance, and facilitating and helping to coordinate the provision of such services not at Veterans' Administration expense, to such eligible veterans when such referral is reasonably necessary for the health of such veterans. The Administrator shall carry out this section (1) in a manner consistent (A) with the policy of the United States, set forth in section 409(a) of Public Law 97-306, that the Veterans' Administration shall maintain a comprehensive, nationwide health-care system for the direct provision of quality health-care services to eligible veterans, (B) with the mandate of section 4101(a) of this title that the Department of Medicine and Surgery shall provide a complete medical and hospital service for the medical care and treatment of veterans, and (C) with the United States Government's historic, firm commitment, and moral obligation, as embodied in this title, to provide care for veterans with service-connected disabilities, and (2) in conjunction with local, State, Federal, and private agencies providing and coordinating the provision of services to elderly persons and with other pertinent public and private agencies.

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PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

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§ 5010. Operation of medical facilities

(a)(1) * * *

* * * * * * *

(B) In order to carry out the provisions of subparagraph (A) of this paragraph, the Director of the Office of Management and Budget shall, with respect to each such law (i) provide to the Veterans' Administration for the fiscal year (or part of a fiscal year) concerned such funded personnel ceiling and the funds necessary to achieve such ceiling, and (ii) submit to the appropriate committees of the Congress and to the Comptroller General of the United States certification that the Director has so provided such ceiling. Not later than the thirtieth day after the enactment of such a law or, in the event of the enactment of such a law more than thirty days prior to the fiscal year for which such law makes such appropriations, not later than the tenth day of such fiscal year, the certification required in the first sentence of this subparagraph shall be submitted, together with a report containing complete information on the personnel ceiling that the Director has provided to the Veterans' Administration for the employees described in subparagraph (D) of this paragraph.

(C) Not later than [the forty-fifth day after the enactment of each such law,] *fifteen days after the expiration of the period for the submission of a certification by the Director of the Office of Management and Budget under subparagraph (B) of this paragraph,* the Comptroller General shall submit to the appropriate committees of the Congress a report stating the Comptroller General's opinion as to whether the Director [of the Office of Management and Budget] has complied with the requirements of such subparagraph in providing *such certification and in providing* to the Veteran's Administration such funded personnel ceiling.

* * * * * * *

APPENDIX C

[From the Congressional Record, Vol. 130, No. 105, pp. S10109-S10135--Senate, Aug. 8, 1984]

VETERANS' ADMINISTRATION HEALTH CARE AMENDMENTS OF 1984

Mr. STEVENS. Mr. President, I ask that the Chair lay before the Senate Calendar No. 929, S. 2514.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will state the bill by title.

The assistant legislative clerk read as follows:

A bill (S. 2514) to amend title 38, United States Code, to enhance the management of Veterans' Administration medical treatment programs by providing for the referral of veterans to non-Veterans' Administration entities and arrangements for additional necessary services, to revise and clarify the authority for the furnishing of care for veterans suffering from alcohol or drug dependence, to require the Administrator to establish the position of Associate Director for Post Traumatic Stress Disorder, to require the Administrator to submit a report to Congress regarding programs of the Veterans' Administration providing hospice and respite care to certain veterans, and to authorize the Administrator of Veterans' Affairs to provide telecaption television decoders to totally deaf veterans in certain cases, and for other purposes.

The Senate proceeded to consider the bill which had been reported from the Committee on Veterans' Affairs with an amendment to strike out all after the enacting clause and insert in lieu thereof:

That (a) this Act may be cited as the "Veterans' Administration Health Care Amendments of 1984".

(b) Except as otherwise specifically provided whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

COORDINATION OF VETERANS' ADMINISTRATION-COMMUNITY REFERRAL ASSISTANCE AND SERVICES

SEC. 2. (a) Chapter 73 is amended by adding at the end of subchapter I the following new section:

"§ 4120. Coordination of referral assistance and services

"In order to improve the provision, and enhance the management, of health-care and health-related services by the Veterans' Administration and other sources to veterans who are eligible for care under chapter 17 of this title, with a special emphasis on veterans who are 65 years of age or older, and who are determined by the Administrator to be in need of assistance under this section, the Administrator shall designate one organizational unit in each Veterans' Administration health-care facility for the purpose of coordinating the provision of referral assistance, and facilitating and helping to coordinate the provision of such services not at Veterans' Administration expense, to such eligible veterans when such referral is reasonably necessary for the health of such veterans. The Administrator shall carry out this section (1) in a manner consistent (A) with the policy of the United States, set forth in section 409(a) of Public Law 97-306, that the Veterans' Administration shall maintain a comprehensive, nationwide health-care system for the direct provision of quality health-care services to eligible veterans, (B) with the mandate of section 4101(a) of this title that the Department of Medicine and Surgery shall provide a complete medical and hospital service for the medical care and treatment of veterans, and (C) with the United States Government's historic, firm commitment, and moral obligation, as embodied in this title, to provide care for veterans with service-connected disabilities, and (2) in conjunction with local, State, Federal, and private agencies providing and coordinating the provision of services to elderly persons and with other pertinent public and private agencies.".

(b) The table of sections at the beginning of chapter 73 is amended by adding after the item relating to section 4119 the following:

"4120. Coordination of referral assistance and services.".

ALCOHOL AND DRUG TREATMENT AND REHABILITATION

SEC. 3. (a) Section 620A is amended—

(1) by striking out "pilot" in subsection (a)(1) both places it appears;

(2) by striking out "fifth" and inserting in lieu thereof "seventh" and by striking out "pilot" in subsection (e);

(3) in subsection (*f*)—

(A) by inserting "(1)" before "Not"; and

(B) by inserting before the period "prior to the amendment of this section by the Veterans' Administration Health Care Amendments of 1984"; and

(C) by adding at the end of the following new paragraph:

"(2) Not later than March 1, 1986, and March 1, 1987, the Administrator shall report to such committees on the findings and recommendations of the Administrator pertaining to the operation of the program authorized by subsection (a) during the preceding fiscal year and shall include in such report information for such year regarding average duration of participation of veterans, rates of successful rehabilitation, and any changes in average and maximum allowable charges per veteran under contracts entered into by the Veterans' Administration as part of such program."; and

(4) by adding at the end of the following new subsection:

"(h) Not later than 12 months after the date of the enactment of this subsection, the Administrator shall prescribe regulations to provide guidelines for the treatment and rehabilitation of veterans for alcohol or drug dependence or abuse disabilities under this chapter in facilities over which the Administrator has direct jurisdiction. Such guidelines shall include guidance—

"(1) on the duration of such treatment and rehabilitation under this chapter, taking into account the duration of such treatment and rehabilitation in non-Veterans' Administration programs and identifying specifically duration in detoxification, inpatient-acute care, inpatient-rehabilitation and extended care, outpatient care, and followup services; and

"(2) on the provision of referral assistance and the development, implementation, and monitoring of individual treatment plans and followup for veterans receiving such care and treatment.".

(b) Not later than March 1, 1985, and March 1 of each subsequent year, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report containing a comprehensive survey of the activities during the preceding fiscal year of all Veterans' Administration-operated programs providing treatment and rehabilitation for alcohol or drug dependence or abuse disabilities, identifying, by facility, the number of beds involved, the number of patients and episodes of care (whether inpatient-acute, inpatient-rehabilitation, inpatient-extended, or outpatient), the specific treatment methodologies employed, average lengths of participation, rates of successful rehabilitation, and staffing levels and standards, together with a national summary of such information. The third such report shall also contain information on the effectiveness of such treatment and rehabilitation in light of the regulations prescribed under subsection (h) of section 620A (as added by the amendment made by subsection (a)(4) of this section), including information on diagnostic methodologies employed, use of case-management approaches and discharge planning, lengths of participation, treatment results, methods used for approving, evaluating, and monitoring the use of non-Veterans' Administration facilities under section 620A, and referral and followup activities for veterans discharged from such programs and such facilities.

(c) The section heading of section 620A and the item relating to such section in the table of sections at the beginning of chapter 17 are each amended by striking out the semicolon and "pilot program".

MEDICAL AND REHABILITATIVE DEVICES

SEC. 4. Section 617 is amended—

(1) by redesignating such section as subsection (a); and

(2) by adding at the end of the following new subsection:

"(b) In order to assist in overcoming the handicap of deafness, the Administrator may provide assistive devices, including telecaptioning television decoders, to veterans who are profoundly deaf and entitled to compensation on account of hearing impairment.".

POST-TRAUMATIC-STRESS DISORDER

SEC. 5. (a)(1) In order to enhance the Veterans' Administration's capability to diagnose and treat post-traumatic-stress disorder (hereinafter in this section referred to as "PTSD"), the Chief Medical Director of the Veterans' Administration shall establish in the Department of Medicine and Surgery a Special Committee on Post-Traumatic-Stress Disorder (hereinafter in this section referred to as the "Special Committee") and shall appoint qualified employees of the Department to serve on the Special Committee.

(2) The Special Committee shall assess, and carry out a continuing assessment of, the capacity of the Veterans' Administration to provide diagnosis and treatment to eligible veterans with PTSD and shall advise the Chief Medical Director regarding the development of policies, the provision of guidance, and the coordination of services for the diagnosis and treatment of veterans with PTSD in inpatient PTSD units, other inpatient psychiatric programs, outpatient mental health clinics, and readjustment counseling programs of the Veterans' Administration. The Special Committee shall also make recommendations to the Chief Medical Director for guidance regarding appropriate diagnostic and treatment methods and referral for and coordination of follow-up care and with respect to the evaluation of PTSD treatment programs, the conduct of research concerning such diagnosis and treatment (taking into account the provisions of subsection (b) of this section), special programs of education and training on PTSD for employees of the Department of Medicine and Surgery and the Department of Veterans' Benefits (also taking into account such provisions), the appropriate allocation of resources for all such activities, and any specific steps that should be taken to improve such diagnosis and treatment and to correct any deficiencies in the oper-

ations of inpatient PTSD units.

(b) The Chief Medical Director of the Veterans' Administration shall establish and operate a National Center on PTSD (A) to carry out and promote research into, and the training of health-care and related personnel in, the diagnosis and treatment of veterans with PTSD, and (B) to serve as a resource center for and to promote and to seek to coordinate the exchange of information regarding all research and training activities carried out by the Veterans' Administration, and by other Federal and non-Fedceral entities, with respect to PTSD.

(c)(1)(A) Not later than 180 days after the date of the enactment of this Act, the Administrator shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report on the implementation of subsections (a) and (b).

(B) The report required by subparagraph (A) shall contain—

(i) a list of the members of the Special Committee,

(ii) the assessment of the Chief Medical Director of the Veterans' Administration, after consultation with the Special Committee, regarding the capability of the Veterans' Administration to meet the needs of Vietnam veterans, former prisoners of war, and other eligible veterans for inpatient and outpatient PTSD diagnosis and treatment (both through PTSD inpatient treatment units and otherwise) as well as a description of the results of any evaluations that have been made of PTSD inpatient treatment units in existence on the date of the enactment of this act,

(iii) the plans of the Special Committee for further assessments for the capability of the Veterans' Administration to diagnose and treat veterans with PTSD,

(iii) the plans of the Special Committee for further assessments of the capability of the Veterans' Administration to diagnose and treat veterans with PTSD,

(iv) the recommendations made by the Special Committee to the Chief Medical Director,

(v) a description of the steps taken, plans made (and a timetable for their execution), and resources to be applied to implement subsections (a) and (b), and

(vi) the assessment of the Administrator of the capacity of the Veterans' Administration to meet in all geographic areas of the United States the needs described in clause (ii) and any plans and timetable for increasing that capacity (including the costs of such action).

(2) Not later than February 1, 1986, and February 1 of each subsequent year, the Administrator shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report containing information updating the report or reports submitted under this subsection prior to the submission of such report.

REPORT ON VETERANS' ADMINISTRATION PROGRAMS FOR TERMINALLY ILL VETERANS

Sec. 6. (a) Not later than September 30, 1985, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report on programs of the Veterans' Administration to furnish palliative care, supportive counseling, and other medical services to terminally ill veterans and, pursuant to section 601(6)(B) of title 38, United States Code, supportive counseling to members of such veterans' families.

(b) The report required by subsection (a) shall include—

(1) a review of Veterans' Administration policies and guidelines on the provision of care, counseling, and services described in subsection (a);

(2) a review of the care, counseling, and services furnished, including the treatment modalities used and services furnished by the Veterans' Administration;

(3) an analysis and a comparison of the care, counseling, and services furnished with respect to terminally ill veterans in hospice and other Veterans' Administration programs, including a comparison of the routine and ancillary services, of the duration of inpatient and outpatient treatment and hospital-based home care, and of the cost of care furnished in such programs;

(4) an explanation of how the care, counseling, and services described in subsection (a) is or will be included in the overall plans of the Veterans' Administration for providing health care to older veterans in the future and tthe extent to which plans to furnish hospice care are included in such plans;

(5) a review of any steps taken to arrange for the exchange of information between Veterans' Administration facilities providing the care, counseling, and services described in subsection (a) and non-Veterans' Administration facilities providing similar care, counseling, and services; and

(6) proposals for such administrative or legislative action as the Administrator may consider appropriate in light of the information provided in the report.

AUTOMOBILE ADAPTIVE EQUIPMENT

Sec. 7. (a) Subsection (c) of section 1903 is amended to read as follows:

"(c)(1) An eligible person shall not be entitled to adaptive equipment under this chapter for more than two automobiles or other conveyances (A) at any one time, or (B) except as provided in paragraph (2) of this subsection, in any four-year period.

"(2) If, in a case in which the limitation set forth in paragraph (1)(B) of this subsection precludes an eligible person from being entitled to adaptive equipment, the Administrator determines that, due to circumstances beyond the control of the eligible person, one of the automobiles or other conveyances for which adaptive equipment was provided in the applicable four-year period is no longer available for the use of such person, the Administrator may, as a matter of discretion and pursuant to regulations which the Administrator shall prescribe, provide adaptive equipment for such person for an additional automobile or other conveyance during such period.".

(b)(1) Except as provided in paragraph (2), the amendment made by subsection (a) shall take effect on October 1, 1984.

(2) In the case of a person who was provided adaptive equipment under chapter 39 of title 38, United States Code, for an automobile or other conveyance after September 30, 1980, but prior to October 1, 1984, and who has available for use such automobile or other conveyance on the date of the enactment of this Act, the first four-year period applicable to such person under subsection (c) of section 1903 of such title (as amended by subsection (a)) shall begin on the most recent date prior to October 1, 1984, on which such individual was provided such equipment.

DEFINITION OF VIETNAM ERA

Sec. 8. Section 101(29) is amended to read as follows:

"(29) The term 'Vietnam era' means (A) the period beginning on August 5, 1964, and ending on May 7, 1975, and (B) the period beginning on February 21, 1961, and ending on May 7, 1975, in the case of a veteran who served in the Republic of Vietnam during such period.".

READJUSTMENT COUNSELING

Sec. 9. (a) Section 612A(g)(2)(B) is amended—

(1) by striking out "and" at the end of clause (i);

(2) by striking out the period at the end of clause (ii) and inserting in lieu thereof a semicolon and "and"; and

(3) by adding after clause (ii) the following:

"(iii) assessments of whether or not individuals who—

"(I) are veterans who served on active duty (aa) during World War II or the Korean conflict (with particular emphasis on those who engaged in combat with the enemy), (bb) during any period and who were prisoners of war, or (cc) after May 7, 1975 (with particular emphasis on those who served in areas during periods in which members of the Armed Forces in such areas were subjected to danger from armed conflict comparable to the danger to which members of the Armed Forces have been subjected in combat with the enemy during a period of war), and

"(II) members of the Armed Forces serving on active duty who (aa) served on active duty during World War II or the Korean conflict (with particular emphasis on those who engaged in combat with the enemy) or after May 7, 1975 (with particular emphasis on those who served in areas during periods described in division (I)(cc) of this clause), or (bb) were prisoners of war,

need readjustment counseling and, if so, the Administrator's recommendations on the most desirable means by which such needs should be met, taking into account the resources that would be required to meet such needs and specifically whether such persons should be made eligible for readjustment counseling under this section and, if so, what effect that eligibility would have on the availability of such services for Vietnam-era veterans.

The Administrator may submit the assessments and recommendations described in subclause (iii) at any time prior to April 1, 1987.".

(b)(1) Not later than 180 days after the date of the enactment of this Act, the Administrator of Veterans' Affairs and the Secretary of Defense shall submit to the appropriate committees of the Congress a joint report setting forth—

(A) their recommendations, taking into account the extent of the availability of Veterans' Administration resources to provide readjustment counseling to Vietnam-era veterans, on the appropriateness and desirability of extending eligibility for readjustment counseling under section 612A of title 38, United States Code, to individuals who are serving on active duty in the Armed Forces of the United States and (i) who also served on such active duty during the Vietnam era (as defined in section 101(29) of such title (as amended by section 8 of this Act)), or (ii) who also served on active duty after May 7, 1975, in an area during a period in which hostilities (as defined in paragraph (2) of this subsection) occurred in such area;

(B) their determinations as to (I) whether, if eligibility for such readjustment counseling were so extended, the Veterans' Administration and the Department of Defense would enter into an agreement or agreements pursuant to which the Department of Defense would reimburse the Veterans' Administration for such counseling provided to such individuals while serving on active duty, (II) if so, whether or not such reimbursement would be made without the necessity of the Veterans' Administration providing the Department of Defense with the names of the individuals so counseled and, if not, whether or not a requirement that such names be provided would discourage active-duty personnel from requesting such services, and (III) the manner and extend to which the Veterans' Administration and the Department of Defense would undertake to carry out outreach activities to inform such individuals about the availability of such counseling; and

(C) any other information, determinations, or recommendations pertinent to the subject matter of the report that the Administrator and Secretary consider appropriate.

(2) For the purpose of paragraph (1), the term "hostilities" means a situation as to which the Administrator, in consultation with the Secretary, finds that members of the Armed Forces in such situation were subjected to danger from armed conflict comparable to the danger to which members of the Armed Forces have been subjected in combat with the enemy during a period of war.

SECURITY SERVICE PERSONNEL

Sec. 10. (a) Section 218 is amended to read as follows:

"§ 218. Security and law enforcement on property under the jurisdiction of the Veterans' Administration

"(a)(1) The Administrator, with the concurrence of the Attorney General, shall prescribe regulations to provide for the maintenance of law and order and the protection of persons and property on land and in buildings under the jurisdiction of the Veterans' Administration and not under the control of the Administrator of General Services (hereinafter in this section referred to as 'Veterans' Administration property'). Such regulations shall prescribe, but need not be limited to—

"(A) rules for conduct on Veterans' Administration property,

"(B) the penalties, within the limits specified in paragraph (2) of this subsection, for violations of such rules,

"(C) policies with respect to the exercise by Veterans' Administration security service officers of the enforcement and arrest authorities granted in subsection (b) of this section,

"(D) the scope and duration of training that is required for Veterans' Administration security service officers, with particular emphasis on dealing with situations involving patients, and

"(E) rules limiting the carrying and use of weapons by Veterans' Administration security service officers.

The rules prescribed under clause (A) of this paragraph, together with the penalties for violations thereof, shall be posted conspicuously on such property.

"(2) Whoever violates any rule prescribed under paragraph (1)(A) of this subsection shall be fined not more than $500 or imprisoned not more than six months (or such lesser amount or period of time as the Administrator prescribes in the regulations prescribed under paragraph (1) of this subsection), or both.

"(b) The Administrater may designate employees of the Veterans' Administration as Veterans' Administration security service officers. Such officers shall enforce Federal laws, and the rules prescribed under subsection (a)(1)(A) of this section, on Veterans' Administration property. Any Veterans' Administration security service officer, subject to any restrictions under the regulations prescribed under subsection (a) of this section, may make an arrest, with or without a warrant, for any offense on Veterans' Administration property if (1) such offense occurs in such officer's presence, or (2) such officer has reasonable grounds to believe (A) that the offense constitutes a violation of any law of the United States or of any rule prescribed under subsection (a)(1)(A) of this section, and (B) that the person to be arrested has committed that offense.

"(c) With the agreement of the head of the agency concerned, the Administrator may use the facilities and services of Federal, State, and local law enforcement agencies when it is economical and in the public interest to do so.

"(d)(1) Notwithstanding subchapter I of chapter 59 of title 5, the Administrator, pursuant to regulations which the Administrator shall prescribe consistent with paragraph (2) of this subsection, may pay allowances for the purchase of uniforms to any Veterans' Administration security service officer who is required to wear a prescribed uniform in the performance of official duties.

"(2) Allowances that the Administrator may pay under paragraph (1) of this subsection shall not exceed—

"(A) at the time the individual is first employed as a Veterans' Administration security service officer, $400; and

"(B) at the beginning of the first fiscal year that begins after the individual has completed 12 months of service as a Veterans' Administration security service officer and at the beginning of each subsequent fiscal year, $200.".

(b)(1) The provisions of section 218 of title 38, United States Code, other than clause (2) of subsection (a) of such section, as in effect on the day before the date of the enactment of this Act shall remain in effect until the date on which the Administrator of Veterans' Affairs prescribes the regulations required to be prescribed by subsection (a) of such section as amended by subsection (a) of this section.

(2) The authority of the Administrator to designate officers and employees of the Veterans' Administration to act as special policemen under section 218(a)(2) of such title as in effect on the day before the date of the enactment of this Act shall remain in effect until the date on which the Administrator first exercises the authority under subsection (b) of section 218 of such title as amended by subsection (a) of this section.

(c) The item relating to such section in the table of sections at the beginning of chapter 3 of such title is amended to read as follows:

"218. Security and law enforcement on property under the jurisdiction of the Veterans' Administration.".

(d) Section 4107(g) is amended—

(1) in paragraph (1)—

(A) by striking out "or" in clause (A);

(B) by striking out the comma and inserting in lieu thereof a semicolon and "or" in subclause (iv) of clause (B); and

(C) by inserting after clause (B) the following new clause:

"(C) of employees providing security services, pursuant to section 18 of this title, in buildings under the jurisdiction of the Administrator (and not under the control of the Administrator of General Services) that are used for the purpose of providing health care,";

(2) by striking out "health-care" each place it appears in paragraphs (2)(A) and (4); and

(3) by inserting "or (C)" after "(B)" in paragraph (4).

COMPTROLLER GENERAL REPORT ON MEDICAL PERSONNEL STAFFING LEVELS

Sec. 11. Section 5010(a)(4)(C) is amended to read as follows:

"(C) Not later than fifteen days after the expiration of the period for the submission of a certification by the Director of the Office of Management and Budget under subparagraph (B) of this paragraph, the Comptroller General shall submit to the appropriate committees of the Congress a report stating the Comptroller General's opinion as to whether the Director has complied with the requirements of such subparagraph in providing such certification and in providing to the Veterans' Administration such funded personnel ceiling.".

REPORT ON FEDERAL GOVERNMENT RESPONSIBILITY TO INDIVIDUALS WHO SERVED WITH VOLUNTARY CIVILIAN ORGANIZATIONS IN VIETNAM

Sec. 12. (a)(1) The purpose of this section is to provide a basis for the executive branch and the Congress to evaluate the question of United States Government responsibility, and alternative approaches, for providing individuals who served for a period of at least thirty days in the Republic of Vietnam during the Vietnam era as employees of voluntary organizations, determined by the Administrator of Veterans' Affairs, in consultation with the Secretary of Defense, to be organizations which provided significant assistance to the United States Armed Forces in the Republic of Vietnam during the Vietnam era, with Federal and other benefits and services (including, but not limited to, health care and monetary compensation for disabilities which may be related to exposure to dioxin or be the result of traumatic events), either through the Veterans' Administration or otherwise, and for assisting such individuals in connection with disabilities they may have incurred as a result of such service.

(2) In order to carry out the purpose stated in paragraph (1), the Administrator, the Secretary of Defense, and the Secretary of Health and Human Services, not later than 180 days after the date of the enactment of this Act, shall submit to the appropriate committees of the Congress a joint report on the question of United States Government responsibility and setting forth various alternative approaches (together with comments on the appropriateness and the advantages and disadvantages of each), and any recommendations by such officials for legislative and administrative action with respect thereto, for establishing a program for providing such benefits, services, and assistance to such individuals.

(b) For the purpose of this section, the terms "Armed Forces" and "Vietnam era" have the meanings given such terms in section 101(10) and (29) (as amended by section 8 of this Act), respectively, of title 38, United States Code.

CONTRACT CARE IN PUERTO RICO AND THE VIRGIN ISLANDS

Sec. 13. Section 601(4)(C)(v) is amended by striking out "September 30, 1984," and inserting in lieu thereof "September 30, 1985,".

PAYMENT FOR THERAPEUTIC AND REHABILITATIVE ACTIVITIES

Sec. 14. (a) Notwithstanding any other provision of law, no amount of remuneration provided to an individual as a participant in a therapeutic or rehabilitative activity carried out pursuant to section 618 of title 38, United States Code, shall be included in determining annual income for purposes of payments of pension (as defined in section 101(15) of such title).

(b)(1) Subsection (a) shall take effect on October 1, 1984, and shall cease to have effect on December 31, 1987.

(2)(A) In the case of each person who on January 1, 1984, was, or on a subsequent date prior to October 1, 1984, became, a participant in an activity under such section 618 and who either (A) continuously participated in such activity from January 1, 1984, or such subsequent date through September 30, 1984, or (B) terminated such participation for the purpose of entering into more remunerative employment, the Administrator of Veterans' Affairs shall pay to such person, from funds in the Veterans' Administration compensation and pension account, an amount equal to the amount of pension (as so defined) that such person would have been eligible to receive by reason of subsection (a) if it had become effective as of January 1, 1984.

(B) This paragraph shall take effect on October 1, 1984.

(c) Not later than February 1, 1987, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report, with respect to fiscal years 1985 and 1986, on the implementation of subsections (a) and (b). Such report shall contain information regarding the numbers of individuals who participated in activities under such section 618, the numbers of such individuals who are in receipt of Veterans' Administration pension, the costs of excluding payments provided for participation in an activity under such section 618 from countable income for Veterans' Administration pension purpose, and the effect of so excluding such payments on the participation of veterans in such activities. Such report shall also and shall include any recommendations of the Administration for legislative or administrative action in light of information contained in the report.

(d) Section 618 is amended by adding at the end the following new subsection:

"(f) Neither a veteran's participation in an activity carried out under this section nor such veteran's receipt of remuneration as a result of such participation shall be considered as a basis for the denial or discontinuance of a total disability rating for purposes of compensation or pension based on the veteran's inability to secure or follow a substantially gainful occupation as a result of disability.".

HEALTH CARE IN REMOTE AREAS

SEC. 15. (a) The Congress finds that—

(1) many veterans with service-connected disabilities and other veterans eligible for certain health-care services from the Veterans' Administration, within the limits of Veterans' Administration facilities, reside in areas of the United States that are geographically remote from health-care facilities over which the Administrator of Veterans' Affairs has direct jurisdiction;

(2) for many such veterans such health-care facilities are geographically inaccessible and for many other such veterans the inconvenience of travel to such facilities discourages them from seeking health-care services from the Veterans' Administration; and

(3) a study conducted by the Administrator of eligible veterans residing in remote areas and these veterans' utilization of Veterans' Administration health-care services would provide useful information on the feasibility and appropriateness of alternative approaches to furnishing health-care services to such veterans.

(b)(1) The Administrator shall carry out a study to develop information about veterans who reside in remote areas and are eligible for health-care services from the Veterans' Administration and to develop alternative approaches that could be adopted to furnish such veterans with such services. In carrying out the study, the Administrator shall—

(A) develop, to the maximum feasible extent, statistics on the number of eligible veterans who, during fiscal year 1985—

(i) reside less than 50 miles from the nearest Veteran's Administration medical facility,

(ii) reside between 50 miles and 100 miles from the nearest Veteran's Administration medical facility,

(iii) reside between 100 miles and 200 miles from the nearest Veteran's Administration medical facility, or

(iv) reside more than 200 miles from the nearest Veteran's Administration medical facility;

(B) develop, by each group of residences described in clause (A), statistics on the numbers of eligible veterans who, during such year—

(i) utilize Veteran's Administration medical facilities,

(ii) receive inpatient care in such facilities (including the typical lengths of stay of such veterans in such facilities),

(iii) receive outpatient care from such facilities, or

(iv) receive followup health-care services from such facilities;

(C) develop such further statistics and gather such additional information as the Administrator considers appropriate to carry out the study; and

(D) develop breakdowns of the statistics described in clauses (A) and (B) with respect to age, service connection, and financial need regarding the applicable veteran populations.

(2) Not later than January 1, 1986, the Administrator shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a full report on such study. Such report shall include—

(A) the statistics and breakdown developed and information gathered pursuant to paragraph (1);

(B) the Administrator's findings on the extent of the need for the Veteran's Administration to increase health-care services in remote areas; and

(C) the Administrator's findings and recommendations regarding the advantages and disadvantages of the Veteran's Administration contracting for and making other arrangements for the furnishing of health-care services to eligible veterans in remote areas.

(3) Not later than July 1, 1986, the Administrator shall submit to such committees a report describing an experimental program that could feasibly be carried out through projects in five remote areas, selected on the basis of the statistics, breakdowns, information, and findings included in the report submitted under paragraph (2), to demonstrate alternative approaches for the Veteran's Administration to furnish health-care services to eligible veterans in remote areas. The report shall also include a description of the health-care services, and a detailed breakdown of the costs for them, that could be furnished under such an experimental program to such veterans in each such area, along with the recommendations (and the reasons therefor) of the Administrator regarding whether any such projects should be carried out and such recommendations for legislative or administrative action as the Administrator considers appropriate in light of the informaton contained in the report.

Amend the title so as to read: "A bill to amend title 38, United States Code, to require the Veterans' Administration to develop guidance for the provision of care to veterans suffering from alcohol or drug dependence, to require the Administrator to establish a Special Committee and a National Center for Post-Traumatic-Stress Disorder, to improve the Veterans' Administration ability to protect persons and property on its premises, and to exempt from being counted for pension purposes remuneration received by veterans in certain rehabilitation therepy programs; and for other purposes."

AMENDMENT NO. 3552

(Purpose: To delete certain provisions involving entitlement spending; to direct the Administrator of Veterans' Affairs to modify the reversionary interest of the United States in certain land previously conveyed to the State of California; to modify the Veterans' Administration's State veterans' home matching fund construction grant program to authorize grants for the acquisition of State home facilities; to express the sense of Congress about certain recommendations of the President's Private Sector Survey on Cost Control relating to the Veterans' Administration health-care system; to authorize the Administrator to modify rates of basic pay for certain psychologists; to name certain Veterans' Administration medical centers; and for other purposes)

Mr. STEVENS. Mr. President, I send an amendment to the desk in behalf of Senators SIMPSON and CRANSTON. It is an amendment to the subcommittee substitute.

The PRESIDING OFFICER. The amendment will be stated.

The assistant legislative clerk read as follows:

The Senator from Alaska [Mr. STEVENS] for Mr. SIMPSON, Mr. CRANSTON, Mr. BOSCHWITZ and Mr. WILSON, proposes an amendment numbered 3552.

(1) On page 15, line 6, strike out "extended" and insert in lieu thereof "inpatient-extended".

(2) On page 23, delete lines 14 through 20.

(3) Redesignate sections 9 through 13 as sections 8 through 12, respectively.

(4) On page 33, lines 15 and 16, strike out "(as amended by section 8 of this Act)".

(5) On page 33, strike out line 22 and all that follows through page 36, line 21.

(6) Redesignate section 15 as section 13.

(7) At the end of the bill, add the following new sections:

USE OF CERTAIN LANDS BY THE UNIVERSITY OF CALIFORNIA

SEC. 14. (a) Notwithstanding the Act described in subsection (b), the Administrator of Veterans' Affairs shall execute such legal documents as are necessary to permit the use of the real property described in subsection (b) (or any portion of such property) for educational or cultural purposes in addition to the use of such property as a research and medical center and for allied purposes. The Administrator may carry out the preceding sentence subject to such terms and conditions as the Administrator determines are necessary in order to protect interests of the United States.

(b) The real property referred to in subsection (a) is the property transferred to the State of California for the use of the University of California by a quitclaim deed dated December 10, 1948, executed by the Administrator of Veterans' Affairs under the Act entitled "An Act to authorize the Administrator of Verterans' Affairs to transfer a portion of the Veterans' Administration center at Los Angeles, California, to the State of California for the use of the University of California", approved June 19, 1948 (62 Stat. 559), and recorded in the land records of the County of Los Angeles, California, at page 307 of book 29032.

(c) Any document executed to carry out subsection (a) shall provide that the property involved shall revert to the United States if it ceases to be used as a research and medical center or for educational or cultural purposes.

ACQUISITION OF BUILDINGS FOR STATE HOME FACILITIES

SEC. 15. Subchapter III of chapter 81 is amended as follows:

(1) Section 5031(c) is amended—

(A) by striking out "term 'construction' means" and inserting "terms 'constructed' and 'construction' refer to"; and

(B) by inserting "the acquisition of existing buildings for use as domiciliary or nursing home care facilities," after "home buildings,";

(2) Section 5032 is amended by inserting "to acquire existing buildings for use as State home facilities for furnishing such care to veterans," after "nursing home care to veterans,"; and

(3) Section 5035(a) is amended—

(A) by striking out "and" at the end of clause (7); and

(B) in clause (8),

(I) by striking out "sections 276a through 276a-5 of title 40" and inserting in lieu thereof "the Act of March 3, 1931 (40 U.S.C. 276a—276a-5)"; and

(II) by striking out the period at the end and inserting in lieu thereof a comma and "and"; and

(C) by inserting at the end the following new clause:

"(9) in the case of a project for acquisition of a facility, reasonable assurance that the estimated total costs of acquisition of the facility and of any expansion, remodeling, and alteration of the acquired facility necessary to meet Veterans' Administration standards shall not be greater than the estimated cost of constructing an equivalent new facility.".

SENSE OF THE CONGRESS REGARDING CERTAIN GRACE COMMISSION RECOMMENDATIONS

SEC. 16. (a) The Congress makes the following findings:

(1) The Department of Medicine and Surgery of the Veterans' Administration, established by an Act of the Congress, represents a national commitment by the Government to meet the medical needs of eligible veterans, especially those who have been disabled as a result of their military service.

(2)(A) Section 409(a) of Public Law 97-306 states that it is the policy of the United States that the Veterans' Administration "shall maintain a comprehensive, nationwide heath-care system for the direct provision of quality health-care services to eligible veterans".

(B) Section 5010(a)(1) of title 38, United States Code, requires the Veterans' Administration to operate and maintain a total of not less than 90,000 hospital and nursing home beds and such additional beds as may be necessary for the Veterans' Administration to meet its contingency obligations to assist the Department of Defense in times of war or national emergency in caring for the casualties of such war or national emergency.

(3) The President's Private Sector Survey on Cost Control (commonly known as and hereinafter referred to as the "Grace Commission") has recommended that Veterans' Administration hospitals reduce the average length of stay of their inpatients to a level comparable to that found in the private sector; however, many Veterans' Administration hospital patients have severe and multiple disabilities requiring extensive treatment.

(4) The Grace Commission has recommended that funds for construction of Veterans' Administration hospitals not already under contract be deleted from the Veterans' Administration budget, that bids be invited from private hospital management companies to lease hospital facilities to the Veterans' Administration under long-term contracts, and that such facilities be managed by private companies under short-term performance contracts.

(5) The Grace Commission has recommended that nursing home construction by the Veterans' Administration be entirely discontinued and that the Veterans' Administration contract for the operation of nursing home care facilities by the private sector.

(6) The Grace Commission has recommended that the Veterans' Administration eliminate such number of Veterans' Administration acute care hospital beds as is necessary to achieve an 80 percent occupancy rate for such beds.

(7) The Grace Commission has recommended that the Veterans' Administration consider converting some underutilized acute health-care facilities to extended health-care facilities and phasing out old hospital facilities which may be in need of replacement or significant reconstruction; however, demographic information compiled by the Veterans' Administration shows a forthcoming major increased demand on the Veterans' Administration from the aging veterans of World War II for acute as well as long-term health care.

(8) A joint study of the Grace Commission's recommendations conducted by the Congressional Budget Office and the General Accounting Office and submitted to Congress in February 1984, concluded that the potential deficit reductions that might result in 1985 through 1987 from implementation of the Grace Commission's recommendations would be much smaller than the three-year savings projected by the Commission.

(9) The Congress desires to reassure veterans that the Congress remains firmly committed to an independent and comprehensive, nationwide health-care system within the Veterans' Administration, capable of providing quality care to eligible veterans.

(b) In light of the findings made in subsection (a), it is the sense of the Congress (1) that the aforementioned recommendations of the President's Private Sector Survey on Cost Control relating to the Veterans' Administration health-care system must be evaluated in light of the national policies described in subsection (a)(2) and in light of the aforementioned factors, and (2) that no action to implement such recommendations should be taken without their policy implications having first been given full and careful consideration, after appropriate hearings, by the Committees on Veterans' Affairs of the House of Representatives and the Senate.

AUTHORITY TO ADJUST RATES OF PAY FOR CERTAIN PSYCHOLOGISTS

SEC. 17. Section 4104 is amended—

(1) by inserting "(other than those described in paragraph (3))" after "psychologists" in paragraph (2); and

(2) by striking out "Certified" in paragraph (3) and inserting in lieu thereof "Clinical or counseling psychologists who hold diplomas as diplomates in psychology from an accrediting authority approved by the Administrator, certified".

PROGRAM GUIDE ON ALZHEIMER'S DISEASE

SEC. 18. Not later than 180 days after the date of the enactment of this Act, the Administrator shall disseminate to appropriate Veterans' Administration medical facilities and submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a program guide to clarify Veterans' Administration policy regarding the authorization and provision of treatment, including diagnosis, information, outpatient services, hospital care, and nursing home care, of veterans who are eligible for services under title 38, United States Code, and who are suffering from Alzheimer's disease and related neurological diseases.

NAMING OF VETERANS' ADMINISTRATION MEDICAL CENTERS

SEC. 19. (a) The Veterans' Administration Medical Center in Murfreesboro, Tennessee, shall after the date of the enactment of this Act be known and designated as the "Sergeant Alvin C. York Veterans' Administration Medical Center". Any reference to such medical center in any law, regulation, map, document, record, or other paper of the United States shall after such date be deemed to be a reference to the Sergeant Alvin C. York Veterans' Administration Medical Center.

(b) The Veterans Administration Medical Center in Milwaukee, Wisconsin, shall after the date of the enactment of this Act be known and designated as the "Clement J. Zablocki Veterans' Administration Medical Center". Any reference to such medical center in any law, regulation, map, document, record, or other paper of the United States shall after such date be deemed to be a reference to the Clement J. Zablocki Veterans' Administration Medical Center.

Mr. STEVENS. I ask adoption of the Simpson-Cranston amendment.

The PRESIDING OFFICER. The question is on agreeing to the amendment.

The amendment (No. 3662) was agreed to.

Mr. SIMPSON. Mr. President, I rise to express my strong support of S. 2514, the proposed "Veterans' Administration Health Care Amendments of 1984," which was approved unanimously by the Committee on Veterans' Affairs on May 9. The provisions of the bill are designed to maintain and improve the quality and efficiency of health-care services provided by the Veterans' Administration to eligible veterans. I believe the committee bill is fair and reasonable and I would urge that my colleagues join me in assuring its passage. The committee intends that the committee bill would enhance the VA's capability to ensure that eligible veterans with certain complex health-care needs are provided with the most appropriate kinds and levels of care and that such care is provided in a coordinated fashion. The committee bill would also enhance the VA's health-care planning processes by examining the demand for certain kinds of health in health-related services.

INTRODUCTION

On March 30, 1984, as chairman of the Senate Committee on Veterans' Affairs, I introduced S. 2514. As introduced, S. 2514 would have, first, required the Administrator of Veterans' Affairs to designate one office at each VA health-care facility to coordinate and arrange for certain health and health-related services in local communities at no expense to the Veterans' Administration; second, required the Administrator to issue regulations related to the care for veterans suffering from alcohol or drug dependence; third, provided the Administrator with specific authority to provide assistive devices for certain hearing impaired veterans, including telecaptioning television decoders; fourth, directed the Administrator to establish the position of Associate Director for Post-Traumatic Stress Disorder [PTSD]; and fifth, directed the Administrator to submit a report to Congress regarding VA hospice and respite programs for terminally ill and chronically ill veterans. On January 24, 1984, I introduced S. 2210. As introduced, S. 2210 would have revised and clarified the eligibility of certain disabled veterans for automobile adaptive equipment.

On April 11, 1984, the committee held a hearing on these bills and a number of other measures and, on May 9, 1984, the committee met in open session and voted to report favorably S. 2514, with an amendment in the nature of a committee substitute and a title amendment. S. 2514 as reported consists of provisions derived with modifications from S. 2514, S. 2210, S. 2269, amendment No. 2850 to S. 2269, and S. 2278.

HIGHLIGHTS OF S. 2514 AS REPORTED

S. 2514, which I will refer to as the committee bill, contains 14 provisions that would enhance the Veterans' Administration's ability to provide high quality health care services to our Nation's veterans in an efficient manner. The committee bill would require the Administrator of Veterans' Affairs to designate one organizational unit in each VA medical facility to help coordinate referrals and facilitate the provision of services not at VA expense when such services are necessary to promote the health of veterans. The committee bill would also extend for 2 years the VA's present discretionary authority to contract with halfway houses and other community-based facilities for the treatment and rehabilitation of veterans with alcohol or drug abuse or dependency disabilities.

It would require the Administrator to prescribe regulations providing guidelines for VA operated treatment and rehabilitation programs for veterans with alcohol or drug dependency or abuse disabilities. It would provide the Administrator with specific discretionary authority to provide hearing impairment assistive devices, including telecaptioning television decorders, to veterans who are profoundly deaf and who are entitled to disability compensation for a hearing impairment. It would require the VA to establish a Special Committee for Post-Traumatic Stress Disorder [PTSD] to assist the Chief Medical Director in developing policies, providing guidance, and coordinating the provision of services for the treatment of veterans with PTSD. It would require the VA to establish a National Center on PTSD to carry out research and training of health care personnel and to coordinate the exchange of information regarding PTSD among all VA and other Federal programs engaged in PTSD research and training activities. It would require the VA to report to Congress on its programs to furnish palliative care or pain relief and supportive care to terminally ill veterans.

It would provide that an eligible veteran may have more than one vehicle at any one time with VA-provided adaptive equipment and provide that the veteran shall not be entitled to automobile adaptive equipment for more than two vehicles in any 4-year period unless, through circumstances beyond the veteran's control, the veteran no longer has the use of one of these two vehicles. It would modify the definition of the Vietnam era to include, in a case of those who served in Vietnam, the period beginning on February 21, 1961 and ending on August 4, 1964. It would require the VA and the Department of Defense to submit a joint report to Congress on issues pertaining to readjustment counseling for active duty military personnel who served in the Vietnam era and for active duty military personnel who served on active duty following the end of the Vietnam era in an area and during the period of hostilities, such as in Beirut and Granada. It would also require the VA, as part of a previously mandated report on the vet center program, to assess and report on whether or not there are needs for readjustment counseling with regard to veterans of prior wars, former prisoners of war, and veterans of post-Vietnam hostilities. It would improve and clarify the VA's authority to provide security on VA property through a force of VA security service officers; authorize a special uniform allowance for such employees; and provide the Administrator with new discretionary authority to increase rates of pay, for recruitment and retention purposes, for such employees.

It would modify the due date of a recurring Comptroller General's report on Office of Management and Budget compliance with statutory requirements related to personnel ceilings for the VA's Department of Medicine and Surgery. It would require the VA, the Department of Defense, and the Department of Health and Human Services to report to Congress on the question of the Federal Government's responsibility with respect to civilians, such as members of the American Red Cross, who worked in Vietnam during the Vietnam era and who may have experienced stressful combat situations or who may have health problems stemming from such experiences. It would extend the VA's authority to provide care for veterans in Puerto Rico and the Virgin Islands on a contract or fee basis until September 30, 1985. It would require the VA to conduct a 3-year demonstration project for veterans participating in incentive therapy and compensated work therapy programs and who are in receipt of VA pension and 100 percent disability compensation for unemployability. And it would require the VA to develop information about veterans who reside in remote areas and are eligible for VA health-care services.

Mr. President, I should like to highlight briefly some of the provisions of the committee bill, which are derived from S. 2514, as introduced.

COORDINATION OF COMPLEX KINDS AND LEVELS OF CARE

The committee bill contains a number of provisions which are designed to improve the VA's ability to target its resources in an efficient and cost-effective manner to provide the most appropriate kinds and levels of health-care services to veterans with certain complex health-care needs. Section 2 of the bill would improve the provision and enhance the management of health care services to veterans eligible for VA medical care by requiring the VA Administrator to designate one organizational unit in each VA medical facility to help coordinate referrals and facilitate the provision of services not at VA expense when such services are necessary to promote the health of veterans.

Currently social work and volunteer services make appropriate referrals on an individual and case-by-case basis, And since 1975, the VA has participated in the "Working Agreement for the Consortium on Information and Referral Services for Older People" which promotes the exchange of information between the VA and the private sector about services for the elderly. This provision is designed to build on and go beyond such activities by encouraging the development of a systematic effort on the part of each and every VA medical facility to develop a network of communication and cooperation to ensure that elderly and certain other veterans are appropriately referred to and receive health-care and other services necessary to improve their health. This is in no way intended to change the mission of the VA to maintain a comprehensive, nationwide health-care system for eligible veterans. Instead this provision would enhance the VA's ability to develop and implement appropriate links between VA and community-based services, particularly those oriented toward meeting the needs of elderly veterans. By increasing the sharing of such information and establishing such a network, improved referrals and therefore the provision of the most appropriate services can be realized.

Section 3 of the bill would extend for 2 years, until October 1987, the VA's discretionary authority to contract with halfway houses and other community-based facilities for the treatment and rehabilitation of veterans with alcohol or drug abuse or dependency problems, would require the VA to submit two reports to Congress on the use of this authority and would delete references to the program as a pilot program.

Mr. President, there are a wide variety of methods in a number of different settings employed to treat persons with alcohol or drug-related disorders or dependencies. Treatment may be provided in inpatient, outpatient, or intermediate settings. Care in community-based peer oriented programs, such as that provided in halfway houses, is designed to provide an appropriate level of treatment in a supportive environment and aid program participants in making the transition between institutionally based treatment and a return to independent living in their communities. The VA has submitted a report to Congress on the effectiveness of the halfway house pilot program. And the VA has said that it favors an extension of the program. The VA believes that it is in many cases medically advantageous and cost effective to provide care in such facilities as compared with providing care in VA facilities.

I support such an extension, but believe that further study is necessary before making any determination concerning the long-term future of the program. The VA's report to Congress, which was not received until after the committee's April 11 hearing, must be thoroughly analyzed prior to making such a determination. In light of the large number of veterans participating in the program, more than 6,000; the large number of contracts awarded, approximately 280; and the cost involved, an estimated $5.7 million in fiscal year 1984 alone, more information about the quality of care, its effectiveness, potential increases in costs, and its future must be obtained.

Mr. President, the second part of this provision would require the Administrator to prescribe regulations providing guidelines for VA-operated treatment and rehabilitation programs for veterans with alcohol or drug dependence or abuse disabilities. The bill would require the regulations to include guidance on the duration of treatment, kinds of treatment provided, use of individual treatment plans, and followup for veterans receiving care and treatment. And the bill would require the Administrator to submit certain reports to Congress on the activities of all VA alcohol and drug treatment programs.

I am deeply concerned about the large numbers of veterans affected by alcoholism and alcohol-related disorders. According to the VA, defined alcoholics or problem drinkers among hospitalized veterans increased from 20 percent in 1970 to 26 percent in 1980. Defined alcoholics or problem drinkers in the under 35 age group increased from 15 percent in 1970 to 35 percent in 1980. And among hospitalized Vietnam-era veteran alcoholics or problem drinkers increased from 13 percent in 1970 to 38 percent in 1980.

Current VA policies and program manuals do exist which give general direction to the alcohol and drug treatment programs throughout the country. However, given the magnitude of the problem, the impact on the veteran's health, and the implications of the problem for expenditure of VA medical care dollars, it is clear that the VA's efforts must be intensified. Current VA policies and manuals regarding treatment for such veterans are broad and general. No specific policies or guidance exists which addresses those veterans who suffer from alcoholism and have multiple problems, such as multiple medical diagnoses, social and financial problems, and those who are at greater risk for relapses and chronic alcoholism. Such complex cases require careful targeting of appropriate kinds and levels of care.

These regulations would produce more consistency and improvement in efforts to treat veterans with complex alcohol-related problems by encouraging the VA to coordinate treatment for veterans throughout the various stages of treatment—detoxification, inpatient care, outpatient care and followup; promote the use of individualized treatment plans; increase efforts to provide follow-up care; and conduct program evaluations to measure the effectiveness of various treatment methods. This provision is designed to provide the VA with total and complete discretion and flexibility concerning medical policies and treatment methods. The reporting requirements would improve the information and statistics currently available on the numbers and health-care needs of veterans with alcohol and drug-related problems.

Section 5 of the committee bill would require the VA to establish a Special Committee for Post-Traumatic Stress Disorder [PTSD] to assist the Chief Medical Director in developing policies, providing guidance, and coordinating the provision of services for the treatment of veterans with PTSD. The committee would advise the Chief Medical Director on the use of appropriate diagnostic and treatment methods, the evaluation of treatment programs for veterans with PTSD, the conduct of research on PTSD, and the use of special education and treatment training programs for VA employees. The bill would also require the VA to establish a National Center of PTSD to carry out research and training of health care personnel and to coordinate the exchange of information regarding PTSD among all VA and other Federal programs engaged in PTSD reserach and training activities. And the bill would require the VA to report to Congress on its implementation of this provision.

Mr. President, PTSD is a troubling and complex disorder. Much uncertainty remains about the disorder, the criteria used to diagnose it and the methods used to treat it. Mental health experts both inside and outside the VA are not in complete accord about PTSD. What is known, however, is that PTSD may be associated with combat experience. And there is no mental health disorder that is more service-related. I believe the VA should take the lead in addressing those uncertainties that remain about the diagnosis and treatment of veterans with PTSD.

Local initiatives at 10 individual VA medical centers across the country have resulted in the establishment of inpatient PTSD units to treat veterans whose PTSD is too severe to be dealt with on an outpatient basis. I believe this is both appropriate and desirable. However, the VA has not demonstrated clear administrative support for these initiatives. Central coordination of treatment programs, general guidance on existing treatment methods, and training of an increased number of VA personnel—in vet centers, inpatient psychiatric units, and in the Department of Veterans' benefits—is needed.

It is intended by this provision that the special committee would draw on the expertise of psychiatrists, psychologists, social workers, other readjustment counseling personnel, academic affairs personnel and others to aid the Chief Medical Director in providing the necessary guidance to the field on this most important matter. The national center would serve as the focal point for research and training on PTSD. I believe this would enable the VA to coordinate its research efforts and provide training in an efficient manner. Sufficient resources must be allocated to treatment, research, and training initiatives in a balanced way to encourage improvements in these three endeavors. In its views and estimates on the VA's budget for fiscal year 1985, the committee targeted 180 full-time equivalent employees [FTEE] and a total of an additional $5.8 million to improve the VA's ability to treat veterans suffering from PTSD. I expect the VA will comply with the committee's recommendation and allocate 180 additional FTEE in fiscal year 1985 for activities related to the diagnosis and treatment of PTSD.

Section 6 of the bill would require the VA to report to Congress on its programs to furnish palliative—pain relief—and supportive care to terminally ill veterans, including a review of the kinds of care furnished, the treatment methods used, and an analysis and a comparison of the care provided in hospice and other VA programs, including a comparison of costs of such care. It would also require an explanation of how such care is or will be included in the VA's plans for providing health care to older veterans.

Mr. President, the VA already provides care and supportive counseling for eligible veterans who are terminally ill and counseling for affected family members. In addition, the VA has initiated a number of alternative methods of care for the terminally ill, including hospice and hospice-like programs. One inpatient hospice program, 10 other hospice-like programs, and a number of the VA's hospital-based home care programs provide special treatment for the terminally ill. However, testimony at the committee's April 11, 1984, hearing revealed that the optimal way to care for the terminally ill is still not known. More information and experience is necessary to determine the most effective methods to control pain, to relieve symptoms, to improve functioning and quality of life, and to relieve feelings of isolation.

The purpose of the report would be to require the VA to assess various treatment programs for the terminally ill, including nonhospice and hospice oriented programs and to consider the advantages and disadvantages of each of these methods and levels of palliative care, supportive counseling, other medical services, as well as cost-effectiveness, staffing requirements, and the mix of routine and ancillary services employed. Because there is no consensus at this time among providers, researchers, and policymakers as to the benefits and cost-effectiveness of alternative methods of care for the terminally ill, the committee believes that an evaluation by the VA would further our understanding about the complex needs of such patients.

Mr. President, there are two additional provisions which we are proposing to delete from the committee bill and defer consideration to a more appropriate time, because the first concurrent budget resolution is still pending and these two provisions, sections 8 and 14 would require a waiver of section 401(b)(1) of the Congressional Budget and Impoundment Control Act of 1974 to be obtained before the consideration of the bill would be in order.

In lieu of requesting such a waiver, it is our intention to offer an amendment which would strike those two sections from the bill. Section 8 would modify the definition of the Vietnam era to include, in the case of those who served in Vietnam, the period beginning on February 21, 1961, the date of the first reported deaths of U.S. soldiers in Vietnam from hostile actions, and ending on August 4, 1964, the day before the starting date of the Vietnam era in current law. Section 14 would require the VA to conduct a 3-year demonstration project—and submit a report to Congress on 2 years, experience—for veterans participating in incentive therapy and compensated work therapy programs and who are in receipt of VA pension and 100-percent disability compensation for unemployability. We intend to include these two provisions in S. 2736, the proposed "Veterans' Administration Benefit Rate Increase and Program Improvement Act of 1984," as reported.

We also intend to offer today as part of an accepted committee amendment to S. 2514 several provisions which have been worked out and agreed to by the committee's ranking minority member, my colleague from California, Senator ALAN CRANSTON. These amendments include an initiative by Senators ALAN CRANSTON and PETE WILSON concerning the University of California at Los Angeles, a proposal by Senators RUDY BOSCHWITZ and LARRY PRESSLER pertaining to the acquisition of State veterans' homes; a proposal by Senator DENNIS DECONCINI expressing the sense of the Congress with respect to certain Grace Commission recommendations; a proposal by Senator DAN INOUYE pertaining to the recruitment and retention of VA psychologists; a proposal by Senator HOWARD METZENBAUM concerning eligible veterans suffering from Alzheimer's disease; and two proposals pertaining to the naming of certain VA medical centers.

Section 16 of the committee amendment expressing the sense of the Congress with respect to certain Grace Commission recommendations states that no action to implement such recommendations should be taken without their policy implications having first been given full and careful consideration, after appropriate hearings, by the Committees on Veterans' Affairs of the House of Representatives and the Senate. I support the intent of this provision to call for a careful examination by the Congress of the policy implications of management improvements such as those proposed by the Grace Commission. At the same time, I do not believe this provision is in any way intended to discourage thoughtful proposals made by the executive branch, the private sector, the Congressional Budget Office, the General Accounting Office or others for management improvements or cost efficiencies with respect to the Veterans' Administration, especially during a period of constrained fiscal resources.

Many VA hospital patients have severe and multiple disabilities requiring inpatient and outpatient services. However, we must bear in mind that this is not solely unique to the VA. The private sector must also provide care for disabled children and adults with individual and multiple impairments and chronic conditions, such as mental retardation, psychiatric disabilities, functional limitations, and other disabilities.

The role of the VA is important in fulfilling its commitment to our Nation's veterans whose disabilities were incurred in or aggravated by military service, especially those whose disabilities are combat related. But we must not diminish the importance of the role played by the private sector in caring for other members of our society who, for other reasons, are also disabled.

Section 18 of the committee amendment would require the VA to disseminate a program guide to VA medical facilities clarifying its policy regarding the authorization and provision of treatment, including diagnosis, information, outpatient services, hospital care and nursing home care, of veterans who are eligible for services under title 38, United States Code, and who are suffering from Alzheimer's disease and related neurological diseases. Mr. President, I would like to clarify certain aspects of this provision. First, this provision does not provide any new authority to furnish, or new eligibility for, health-care services from the VA. Second, the provision also does not mandate the content of the agency policies that would be stated in the guide with respect to the VA's use of its existing statutory authority to provide health-care services with respect to Alzheimer's disease. Instead this provision is designed to result in a clarification of the VA's policy with respect to the treatment of already eligible veterans who may be suffering from Alzheimer's disease.

Mr. President, in concluding I should wish to sincerely thank my friend, the distinguished ranking minority member from California, Senator Cranston, for his invaluable help and cooperation on this bill and the other committee members for their contributions.

In addition, I should like to recognize and the thank the very able members of the majority staff for their efforts—my chief counsel and staff director, Anthony Principi, Julie Susman, Cynthia Alpert, a highly professional and dedicated member of my staff who handled much of the work for the hearing and the bill, Vic Raymond, Kathleen McTighe, Tim Smith, Carol DeAngelus, Becky Hucks, Kay Eckhardt, Jody Sanders, and our editorial director, Jim MacRae, as well as members of the capable minority staff—Jonathan Steinberg, Ed Scott, Bill Brew, Babette Polzer, Katy Burdick, Jennifer McCarthy, Ingrid Post and Charlotte Hughes.

I also wish to take the opportunity to extend my good wishes to Katy Burdick of the minority staff, who will soon be leaving the committee to pursue graduate work in the area of public health. I can say with all certainty that she will be truly missed by both sides of the aisle. Her work and professionalism have been of the highest caliber; her dedication has admirable. I am confident that she will excel in all her future endeavors.

Mr. President, I believe the committee has reported out a bill which is well-balanced, and one that meets the needs of our most deserving veterans. On behalf of the entire committee, I urge the Senate's favorable consideration of this bill and amendment.

Mr. CRANSTON. Mr. President, as the ranking minority member of the Committee on Veterans' Affairs, I am delighted to join with my good friend, the distinguished committee chairman [Mr. Simpson], in urging our colleagues to give their unanimous approval to the pending measure, S. 2514, the proposed Veterans' Administration Health Care Amendments of 1984, as modified by the amendment offered on behalf of the chairman and myself. I will describe the amendment in more detail at the end of my statement.

Mr. President, S. 2514 as reported by the committee on May 25 incorporates the provisions of a variety of measures, the two principal ones being S. 2514 as introduced by the chairman on March 30, 1984, and S. 2269 which I introduced on February 7, 1984, with the cosponsorship of Senators Randolph, Matsunaga, and DeConcini, and which was subsequently amended by amendment No. 2850. If enacted, this measure will help to maintain and improve the quality and efficiency of health care services provided by the Veterans' Administration to eligible veterans. Although the various provisions of the measure, which I will refer to as the committee bill, are described in detail in the committee's report—Senate Report 98-487—accompanying S. 2514, I would like to highlight some of them.

VA SECURITY SERVICE PROVISIONS

Mr. President, I am very pleased that the committee bill, in section 10, contains a number of provisions derived from legislation I proposed to enable the VA to improve its recruitment, retention, and management of security service personnel. The record is clear: The VA is and has been experiencing significant difficulties in attracting and, more importantly, keeping qualified security personnel. In far too many areas of the country, the VA police force serves as the training ground for individuals who are interested in careers in police or security work but who leave the VA as soon as they acquire the experience they need to obtain jobs with higher pay and greater potential for advancement. The new authorities in the committee bill should go a long way toward helping to solve these problems and, thus, should yield significant improvements in overall security at VA health care facilities.

Mr. President, these provisions would give the Administrator new authorities to modify rates of pay for VA security service officers and to pay a special clothing allowance to uniformed officers. In addition, these provisions would clarify the Administrator's authority to provide for security on VA property and designate individuals to serve as VA security service officers and would require the Administrator, with the concurrence of the Attorney General, to issue regulations relating to these employees, including their authority to make arrests, the content and duration of their training, limitations on their carrying and use of weapons, and certain other law enforcement matters.

More specifically, the provisions in the committee bill—derived from section 6 of S. 2269—relating to rates of pay would provide the Administrator with new authority to increase the rates of basic pay for security service officers where that is necessary either to provide rates of pay competitive with the rates paid by non-Federal employers in the same labor market, to achieve adequate staffing at particular facilities, or to recruit persons with specialized skills. This authority could be exercised on a nationwide, local, or other geographic basis, thereby giving the Administrator maximum flexibility to set rates of pay in response to local situations and conditions.

The other provision in the committee bill that should have the greatest impact on the agency's ability to recruit and retain security service personnel would authorize the Administrator to pay a uniform allowance to those VA security officers required to wear a uniform in the performance of official duties. These provisions—derived from amendment No. 2850 that I submitted on March 27—would authorize the payment of up to a $400 allowance at the time an individual is first employed as a VA security service officer, so as to assist with the purchase of initial uniforms, and a $200 allowance at the beginning of each fiscal year after the individual has completed 12 months with the VA to help these personnel replace and maintain their required uniforms.

In its April 11 testimony, the VA, in endorsing this uniform allowance provision, stated:

> One source of recruitment/retention problems is the low morale and financial hardship resulting from the fact that required uniforms cost much more than the authorized uniform allowance provides. Currently, VA police officers are allowed a flat $125 annually.

The VA went on to note that, in the agency's view, "no one should have to suffer a financial disadvantage in order to work as a VA police officer, and the uniform allowance provisions would help prevent that." I strongly agree with that view and expect that the uniform allowance proposed in the committee bill will help correct this situation.

POST-TRAUMATIC-STRESS DISORDER

Mr. President, although the VA had made some strides in the diagnosis and treatment of post-traumatic-stress disorder [PTSD], I am concerned that the agency could and should be doing much more and doing it in a better coordinated fashion. The efforts to date—principally through the VA's 136 vet centers and the relative handful of PTSD inpatient treatment units, of which there are 10 open at present with an 11th scheduled to open shortly—have lacked any coherent, overall plan.

PTSD is a disorder that is particularly prevalent among veterans and especially so among Vietnam combat veterans. Indeed, combat is one of the stressors identified in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, third edition, as a cause of the disorder. Thus, I believe that the VA has a very strong obligation to be at the forefront of efforts to understand and treat PTSD, just as the agency has in the past taken leadership roles with respect to other conditions, such as spinal cord injuries and amputations, that result from service disproportionately more often than they occur in the civilian population.

To encourage and foster the VA's efforts in this area, the committee has twice urged the VA in committee reports—Senate Report No. 97-89 accompanying S. 921 in the 97th Congress and Senate Report No. 98-145 accompanying S. 578 in the first session of this Congress—to consider seriously the establishment of a national center of excellence where research into diagnosing and treating PTSD would take place and also where training of health-care personnel on diagnosing and treating PTSD would be provided. In addition to the committee's urgings, I have personally pursued, in letters to the VA's Chief Medical Director, the need to establish such a center as well as the need for greater geographic accessibility of PTSD inpatient treatment facilities. The text of this correspondence was included in the RECORD earlier this year—daily edition for March 27, 1984, beginning on S3250—and I ask unanimous consent that the text of the most recent response from the VA on this issue, dated April 20, 1984, be printed in the RECORD.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

VETERANS' ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, DC, April 20, 1984.

Hon. ALAN CRANSTON,
Ranking Minority Member, Committee on Veterans' Affairs, U.S. Senate, Washington, DC.

DEAR SENATOR CRANSTON: Thank you for your letter of March 23, 1984, continuing our dialogue on the issue of Post-traumatic Stress Disorder inpatient programs.

In my letter to February 22, 1984, I indicated that there is "less than unanimity among our psychiatric staff as to the desirability of these units." The fundamental issue addressed by my comment is that of professional judgment. Many competent VA psychiatrists have differing professional opinions about the best approach to the treatment of Vietnam veterans with severe Post-traumatic Stress Disorder and associated conditions. Some clinicians believe that hospital treatment is the most effective approach to treatment of Post-traumatic Stress Disorder while other clinicians believe that outpatient psychotherapy is a better approach. The staff of Mental Health and Behavioral Sciences Service strongly supports the development of local initiatives for the treatment of Post-traumatic Stress Disorder in the belief, based upon years of experience, that rigidly defined centrally directed treatment programs often fail because they cannot take into account the wide differences between individual VA medical centers, their catchment areas, and their clientele.

The statement in the Vanguard reflects the fact that VA Central Office is committed to supporting local initiatives to develop necessary treatment programs. There is no discussion about "desirability of these programs" in Central Office because there is no disagreement about this question. I believe that these programs are "desirable," but I do not intend to direct their formation according to a prescribed formula from Central Office. In addition, I would point out that exploration of alternative approaches to the treatment of Post-traumatic Stress Disorder such as day hospital programs, outpatient programs, and other programs will be considered as appropriate at individual medical centers.

Concerning the unit at Lyons, New Jersey, it was not mentioned in my last letter because it did not seem to be pertinent to the questions asked of me by you and your staff. The decision to begin development of this unit was made during formation of the 1983 MEDIPP plan.

The discussions concerning the development of a VA center for Post-traumatic Stress Disorder have included a number of members of my staff including Dr. Earl Brown, Dr. Arthur Blank, Dr. John Lopkin, and the members of the Administrator's Advisory Group on Readjustment Problems of Veitnam veterans. I have received a preliminary proposal for such a center from the Cleveland VAMC, and I fully expect to make a decision on its implementation within 60 days.

Dr. Arthur Blank participates actively in the Department of Medicine and Surgery's discussions concerning Post-traumatic Stress Disorder. His opinion is regularly sought by members of my staff responsible for treatment, education and research activities.

Interest in the development of a center has been expressed by medical centers which house several of the existing Post-traumatic Stress Disorder units including Bay Pines, Florida, and Menlo Park, California. In addition, because of proposals to provide staff and FTEE for Post-traumatic Stress Disorder units a number of other medical centers have expressed interest informally.

I am enclosing current cost estimates which were prepared concening the staffing of both treatment units and PTSD centers.

Concerning the designation of a National Resources Center for PTSD raised by Senator Simpson, I must reiterate that I have not designated any VAMC as a National Resource Center for Post-traumatic Stress Disorder. The Topeka, VA Medical Center, therefore, has not received additional funds for this purpose. What did, in fact, occur is that the VAMC Topeka agreed to accept referrals nationally for treatment in its Post-traumatic Stress Disorder unit. I do not intend to designate any PTSD unit as the National Resource Center for Post-traumatic Stress Disorder, because I believe that it is prefeable to have district or regional resources for Post-traumatic Stress Disorder so that veterans may be treated closer to their homes, families, and jobs.

If the 1985 budget includes 180 FTEE and 5.8 million dollars "to improve the VA's ability to treat veterans suffering from Post-traumatic Stress Disorder," I intend to allocate approximately 90 FTEE and associated dollars to supoort staffing improvements at the existing programs. The remaining 90 FTEE and dollars will be used to support the development of new programs as requests from local medical districts are received.

I trust that you will find this information useful.

Sincerely,

DONALD L. CUSTIS, M.D.
Chief Medical Director.

COST ESTIMATE POST-TRAUMATIC-STRESS DISORDER UNITS SENATE BILL 2269

The Department of Medicine and Surgery has developed cost estimates for Post-Traumatic Stress Disorder research, education and clinical care programs as proposed in House Bill 4833. Although the House Bill recommends the development of 15 centers, DM&S expects that between four and six centers will be a more reasonable number.

If, as recommended in Senate Bill 2269 the Veterans Administration is to build only one National "Center for Post-traumatic Stress Disorder" its budget will have to be significantly larger than the budget for six somewhat smaller geographically disbursed centers.

A National Center for Post/traumatic Stress Disorder will also have a more broadly defined responsibility to provide treatment, education, and research concerning all forms of Post-traumatic Stress Disorder. Specifically, such a center will attempt to study and treat veterans from all era's, and selected civilian populations with Post-traumatic Stress Disorder.

Preliminary planning for such a center suggests that it will need between 50 and 75 FTEE and will cost between 3.5–4.5 million dollars per year or 22.5 million dollars for five years.

Although there are some advantages to the development of a single national center for Post-traumatic Stress Disorder such as the development of a "critical mass" of clinical, academic and research oriented professionals, there are also some disadvantages. Development of several somewhat smaller centers for Post-traumatic Stress Disorder will allow better geographic distribution of educational and research expertise, and will enhance our ability to develop new information by allowing several groups to pursue research in differing directions.

H.R. 4833—COST ESTIMATE

Separate four-year cost estimates are provided for (1) PTSD treatment (only) units and (2) PTSD treatment, education and research centers. Attached are the assumptions and rational on which these estimates are based.

PTSD TREATMENT (ONLY) UNITS (COST FOR 1 UNIT)

	Treatment costs per 30-bed unit	Basic clinical training costs	Total treatment and basic training per unit
Year 1	$1,201,053	$31,500	$1,232,553
Year 2	1,201,053	28,900	1,229,953
Year 3	1,201,053	30,600	1,231,653
Year 4	1,201,053	29,300	1,230,353
Total	4,804,212	120,300	4,924,512

PTSD TREATMENT, EDUCATION, AND RESEARCH CENTERS (COST FOR 6 CENTERS)

	Number of centers	Cost			Total cost
		Treatment and basic training	Education	Research	
Year 1	2	$2,462,256	$40,000	$550,000	$3,052,256
Year 2	3	3,693,384	60,000	825,000	4,578,384
Year 3	5	6,155,640	100,000	1,375,000	7,630,640
Year 4	6	7,386,768	120,000	1,650,000	9,156,768
Total		19,698,048	320,000	4,400,000	24,418,048

I. ASSUMPTIONS AND COST ESTIMATE FOR TREATMENT (ONLY) UNITS

A. Assumptions

1. Based on available estimates, Vietnam theater veterans with post-traumatic stress disorder (PTSD) range as high as 750,000 veterans.

2. 10 percent of these veterans, or 75,000 patients, will need care in the future for PTSD or other psychiatric disorders.

3. 10 percent recidivism rate per year.

4. 45-day average length of hospital stay (despite current experience which suggests that 90–180 days is more usual) and 100 percent occupancy.

5. 30-bed treatment units (current range 10–30 beds).

6. An average length of stay of 30 days will allow treatment of 5,475 patients per year.

7. Basic training (e.g., problem recognition, diagnosis and treatment) will be provided at each treatment site.

B. Cost estimates for one unit

Staffing pattern per 30-bed treatment (only) unit:

Type	Salary	FTEE	Cost
Psychiatrist	$80,000	2	$160,000
Psychologist	40,972	2	81,944
Social worker	28,750	2	57,500
Nurse	25,159	15	377,385
Nursing assistants	15,681	9	141,129
MAS	23,761	2	47,522
Vocational rehab	23,761	1	23,761
Educational specialist	40,972	2	81,944
Research coordinator	40,972	1	40,972
Total		36	1,012,157

Additional staffing per unit (4 FTEE outpatient therapists and secretarial support to provide screening, follow-up care, etc.):

Type	Salary	FTEE	Cost
Psychiatrist	$80,000	1	$80,000
Psychologist	40,972	1	40,972
Social worker	28,750	1	28,750
Nurse	25,159	1	25,159
Secretary	14,015	1	14,015
Total		5	¹188,896

¹ For a new program, additional costs would include dietetics support, pharmacy support, lab support, etc. Per unit, this would include 41 FTEE and $1,201,053 for clinical services. This includes basic support to research and educational development of each PTSD center (3 FTEE).

Basic clinical education and training for treatment (only) units:

The following estimated funding requirements are based on Professional Services' (116) plan for district Post-Traumatic Stress Disorder (PTSD) Centers which will provide continuing education for both Center staff and other related VA staff. Training of nongovernmental staff will focus on academic health centers and professional societies at both national and regional levels, according to Professional Services' program plan.

	Training of PTSD staff	Training of VA staff	Training of non-government health personnel	Total (per unit)
Year 1	$21,600	$3,300	$6,600	$31,500
Year 2	14,000	3,300	11,600	28,900
Year 3	14,000	3,300	13,300	30,600
Year 4	14,000	3,300	12,000	29,300
Total	63,600	13,200	43,500	120,300

These estimates are based on a projection of 1,106 training episodes over the 4-year life of the program for VA nongovernmental participants. The total costs include travel and non-travel costs. No FTEE are required.

	Number of centers	Cost per center	Total cost
Education:			
Year 1	2	$20,000	$40,000
Year 2	3	20,000	60,000
Year 3	5	20,000	100,000
Year 4	6	20,000	120,000
Total			320,000
Research:			
Year 1	2	275,000	550,000
Year 2	3	275,000	825,000
Year 3	5	275,000	1,375,000
Year 4	6	275,000	1,650,000
Total			4,400,000
Summary:			
Year 1	2		3,052,256
Year 2	3		4,578,384
Year 3	5		7,630,640
Year 4	6		9,156,768
Total			24,418,048

C. Cost summary per treatment unit by year

	Treatment	Basic training	Total
Year 1	$1,201,053	$31,500	$1,232,553
Year 2	1,201,053	28,900	1,229,953
Year 3	1,201,053	30,600	1,231,653
Year 4	1,201,053	29,300	1,230,353
Total	4,804,212	120,300	4,924,512

II. ASSUMPTIONS AND ESTIMATED COSTS FOR SIX TREATMENT, EDUCATION AND RESEARCH CENTERS

A. Assumptions

1. Education and Research costs are in addition to costs of the basic treatment unit as defined in Section I.

2. Per Center, additional costs above and beyond basic training total $20,000.

3. Research costs per Center include one clinical investigator plus $200,000 in project research funds and support additional direct and indirect projects costs.

4. The schedule of Center start-up will be as follows:

	New centers	Total number in operation
Year 1	2	2
Year 2	1	3
Year 3	2	5
Year 4	1	6

B. Cost estimate

Treatment unit:

	Number of centers	Cost per center ¹	Total cost
Year 1	2	$1,231,128	$2,462,256
Year 2	3	1,231,128	3,693,384
Year 3	5	1,231,128	6,155,640
Year 4	6	1,231,128	7,386,768
Total			19,698,048

¹ Assumes average annual cost of $1,231,128 per center.

Mr. CRANSTON. Mr. President, although there has been some progress in recent months toward the establishment of such a national center at the Cleveland VA Medical Center, I remain convinced—especially in view of the committee's prior experience of twice having recommended the establishment of such a center with no results and the lack of certainty regarding the agency's commitment of resources to the proposed center in Cleveland—that a legislative mandate is warranted as a means to help ensure that the center is established and that, thereafter, its operations are afforded a high priority. Such a provision, derived from amendment No. 2850, is contained in section 5 of the committee bill.

In addition to mandating the establishment of a national center for PTSD research and the training of health care personnel in the diagnosis and treatment of this disorder, the committee bill also directs the VA to establish a special, inhouse committee on PTSD to assist the VA's Chief Medical Director in developing policies and providing guidance with respect to, and coordinating the provision of services for, the treatment of veterans with PTSD. Although I can appreciate the VA Central Office's reluctance to dictate any single approach on how to diagnose and treat veterans suffering from PTSD, I believe it is past time for the agency and the Department of Medicine and Surgery to assume a true leadership role in this area. The PTSD committee that would be mandated by the committee bill is an important step in that direction, and something like it should be established by the Chief Medical Director regardless of whether or not it is ultimately mandated by law.

READJUSTMENT COUNSELING REPORTS

Mr. President, as I described in detail in my introductory remarks on S. 2269, on February 7, 1984, that legislation would have made a number of changes in the criteria for eligibility for VA readjustment counseling services. Chief among these changes were ones to extend such eligibility to veterans who have served since the end of the Vietnam era—May 7, 1975—in combat or combat-like situations. My intent in proposing this change was to provide eligibility for readjustment counseling to individuals who were exposed to hostile fire in situations—such as during the invasion of Grenada or in Beirut—that might lead to readjustment problems following their service.

In addition, because of my view that readjustment problems might also exist among active duty personnel, S. 2269 as introduced would have extended eligibility for readjustment counseling to active duty personnel who served during the Vietnam era or served in combat or combat-like situations since that time.

As is discussed in the committee report accompanying the committee bill, instead of my original proposals, the bill includes, in section 9, provisions mandating two reports. The first, to be submitted by the VA, would assess the need for readjustment counseling among veterans not currently eligible for it, including those who have served since the end of the Vietnam era in combat or combat-like situations and, as I also proposed be included in the report, World War II and Korean conflict veterans, with particular emphasis on combat veterans, and former prisoners of war. The second report, to be submitted jointly by the VA and DOD, would deal with, first, the appropriateness and desirability of extending eligibility for readjustment counseling to certain active duty personnel and, second, if such eligibility is provided, then how it could be implemented in a way that VA and DOD could both accept.

Although I am disappointed that my original proposals to extend eligibility for readjustment counseling to certain veterans and active duty personnel are not going forward at this point, I believe that the two reports that we are mandating will provide a basis for appropriate action at some future time.

HEALTH CARE IN REMOTE AREAS

Mr. President, another provision in the committee bill, section 15, would require the VA to study and report on the issue of the utilization of VA health care facilities by veterans eligible for VA health care who reside in areas remote from such facilities. After the completion and submission of this report, the agency would also be required to submit a subsequent report on a possible experimental program that the VA might pursue to furnish VA care to veterans residing in such areas.

This provision was developed by my good friend from Maine [Mr. Mitchell] and derives from his bill, S. 523. It is the culmination of his diligent and thoughtful work over the past 2 years on the issue of VA health care for veterans in rural areas. I congratulate Senator Mitchell for these efforts and for his persistence. Along with him, I look forward to the enactment of this provision and to the VA's pursuit of the mandated study, which is designed to yield important, reliable data about the location, number, and distribution throughout the United States of veterans with various eligibilities for VA care. Once such data are available, the committee will be in a much better position to evaluate VA efforts to date to meet the health care needs of veterans in rural areas and to assess alternative approaches for doing that.

REPORT ON FEDERAL GOVERNMENT ASSISTANCE TO INDIVIDUALS WHO SERVED IN VIETNAM AS CIVILIANS

Mr. President, in response to concerns from a number of non-Federal civilians who served in Vietnam during the Vietnam era with voluntary organizations—principally the Red Cross and the USO—about the effects of their service on their health and the Federal Government response to their concerns, the committee bill, in section 12, contains a provision mandating a joint report from VA, DOD, and HHS on this issue. This provision is derived from section 9 of S. 2269. The required report would evaluate the question of U.S. Government responsibility, and alternative approaches, for providing Federal and other benefits, services, and assistance to these civilians for disabilities that possibly result from certain aspects of their service in Vietnam—such as exposure to agent orange or to particularly traumatic events.

For those who served in Vietnam with the military, there can be no question about the Federal Government's responsibility to address concerns they raise regarding adverse health effects of service in Vietnam—whether as a result of exposure to herbicides such as agent orange or through experiences there. In the case of these former service members, it is also very clear that it is the VA which bears the majority of this responsibility. Thus, our committee has engaged in considerable activity in seeking responsive Federal Government action to deal with concerns regarding the long-term health effects of Vietnam service, with special attention to the question of the long-term health effects of exposure to herbicides, such as agent orange, which were sprayed in Vietnam by the U.S. military as a means of depriving the enemy of cover and food.

In view of the contribution that the individuals who served with voluntary organizations in Vietnam provided to their country and their concerns about the long-term health effects of their Vietnam service that may be related to actions of the Federal Government, I believe that the Federal Government has the responsibility, at least, to evaluate these concerns and consider possible appropriate alternatives—Federal and non-Federal—for addressing them.

I note that this report requirement in no way is intended to prejudge the question of Federal responsibility for assistance or to reflect a judgment by the committee regarding the military or nonmilitary status of any group of civilians who served in Vietnam for the purposes of receiving veterans benefits. A mechanism, the Department of Defense/Civilian Military Review Board, established pursuant to section 401 of Public Law 95-202, already exists to weigh evidence and pass judgment as to whether a particular civilian group's service to the country during a period of war was such that it should be considered military service for the purpose of receiving veterans benefits. The provision in the committee bill is designed neither to circumvent nor influence this separate avenue of redress; rather, I view the issue that this provision is addressing—the question of the existence and extent Federal responsibility to these individuals and the need for an evaluation of alternatives for providing an avenue of redress for them—as entirely separate from the issue of veteran status.

CONTRACT CARE IN PUERTO RICO AND THE VIRGIN ISLANDS

Mr. President, a final health care provision that I wish to comment on, section 13, would provide a 1-year extension—until September 30, 1985—of the VA's authority to provide on a contract basis in Puerto Rico, the Virgin Islands, and other territories of the United States, hospital care for nonservice-connected disabilities and certain outpatient treatment. This provision was proposed in amendment No. 2850. As is discussed in great detail in the committee report, the issue of how to meet these needs has been discussed and studied since 1978 and various alternatives have been developed. To date, however, the VA has been unable or unwilling to settle on a particular approach for addressing this issue and to take the necessary steps to implement it. As a result, the Congress has had to provide a series of short-term extensions of the contract authority. Although the extension proposed in the committee bill is necessary to ensure the continuity of medical care for certain veterans in the areas concerned, it is essential that the VA develop and submit to the Congress a report containing plans for meeting the future health care needs of veterans in Puerto Rico and the Virgin Islands. It is time to put an end to this lingering indecision.

In this regard, I note that the committee emphasized the importance that it attaches to the need for an overall plan for providing health care in Puerto Rico when, earlier this year in connection with the VA's fiscal year 1985 budget submission, the committee deferred action on the agency's request for the construction of a nursing home in Puerto Rico. In taking this action, the committee expressed the view that it would be unwise to proceed on a piecemeal basis with a single project in Puerto Rico without knowing the priority that the VA would attach to that project in comparison with other possible projects or other veterans' health care funding needs in Puerto Rico.

I remain deeply and strongly committed to the principle that the Federal Government must meet its obligation to those who served the Nation in its hours of need, and I will continue working to ensure that those obligations are met in Puerto Rico no less than anywhere else. To do so in a thoughtful, appropriate fashion, however, requires submission by the VA of a comprehensive plan setting forth and evaluating various alternative approaches for providing health care to veterans in Puerto Rico and the Virgin Islands.

AUTO ADAPTIVE EQUIPMENT

Mr. President, in addition, I want to make mention of the provisions of section 7 of S. 2514, relating to automobile adaptive equipment for certain veterans with service-connected disabilities. These provisions are derived from S. 2210 as introduced by the chairman and from a proposal I made at the committee's April 11 hearing. They would generally limit the frequeny with which adaptive equipment is provided to no more than two adaptations in any 4-year period and would allow an eligible veteran to have at any one time VA provided adaptive equipment on two vehicles that are available for his or her use. If, as a result of circumstances beyond the veteran's control, the veteran no longer has the use of one of the VA-equipped vehicles, the provision would authorize the Administrator to provide adaptive equipment for a third vehicle within the applicable 4-year period.

I believe the approach in the committee bill is an improvement over the present situation where, under the adaptive equipment program, a veteran may receive as many as three adaptations in a 2-year period but may never have the use of more than one such adapted vehicle at any one time. The committee bill recognizes the importance and necessity of permitting seriously disabled veterans to have access to a backup means of transportation and represents what I believe is a practical, workable solution to the problems that exist in this program under current law and VA policy. It was a pleasure to work closely with Chairman Simpson and the veterans' organizations, principally the Disabled American Veterans and the Paralyzed Veterans of America, in reaching this approach which accommodates all of our concerns.

SIMPSON-CRANSTON AMENDMENT

Mr. President, as I mentioned at the outset of my remarks, I want to discuss the amendment offered to the committee bill on behalf of Chairman Simpson and myself. As I will describe in more detail, this amendment would delete two provisions from the bill and would add provisions derived from various other measures.

DELETIONS FROM COMMITTEE BILL

The amendment proposes—solely for the purpose of avoiding a Budget Act problem at this point—the deletion from the committee bill of the two provisions that involve so-called entitlement spending. As the author of those provisions, I want to stress that they are being deleted here solely for a technical purpose and will be pursued in other legislation this year. One provision would modify the starting date of the Vietnam era for title 38 purposes in the case of veterans who actually served in Vietnam prior to August 5, 1964, the starting date for the Vietnam era in current law, and would, among other benefits, result in providing VA pension eligibility under chapter 15 of title 38 to a small number of these veterans. The other provision would require the VA to carry out a demonstration project under which income received by veterans for their participation in a VA incentive or compensated work therapy program would not be counted as income for the purposes of VA pension. In light of the fact that the Congress has not yet adopted a first concurrent resolution on the fiscal year 1985 budget, it would not be in order, under the Congressional Budget Act, to consider these entitlement provisions without a Budget Act waiver. Rather than seek such a waiver, the chairman and I are proposing to delete these two provisions from the committee bill and, instead, to have them added to S. 2736, the proposed Veterans' Administration Benefit Rate Increase and Program Improvement Act of 1984 as ordered favorably reported by our committee on July 26, 1984. Further, because that measure contains cost-of-living increases and other adjustments in VA entitlements, if the first resolution on the fiscal year 1985 budget is not adopted by the time that that measure should come before the Senate, our committee will propose a Budget Act waiver resolution pursuant to section 303(c) of that act.

PROVISIONS OF SIMPSON-CRANSTON AMENDMENT, REVERSIONARY INTEREST IN CERTAIN LAND IN LOS ANGELES

Mr. President, the Simpson-Cranston amendment includes a provision relating to the status of a parcel of land in West Los Angeles, CA. This provision, which closely follows H.R. 2629, legislation introduced by my good friend who represents the congressional district in which the land is located, Mr. BEILENSON, is included in the amendment on behalf of myself and my colleague from California [Mr. WILSON]. All three of us have been working for some months to resolve questions regarding this matter and to bring this legislation before the Senate. I know Senator WILSON shares my satisfaction that we have finally achieved that goal.

The parcel of land in question was originally deeded in 1948 by the VA to the State of California for use by the University of California. The public law which authorized the transfer—Public Law 726, 80th Congress—and the deed entered into pursuant to that law specified that the land was to be used only for a "research and medical center and for allied purposes." In light of the fact that UCLA's medical center and supporting facilities are concentrated in an area north of the subject parcel of land and the bulk of the land has gone unused by the university except for two medical facilities, H.R. 2629 and the provision in the amendment would expand the permissible uses to include educational and cultural purposes. Two such uses under consideration by the university, both of which would be permitted under the proposed expanded uses, are as a site for a plasma physics laboratory and a fine arts center.

Mr. President, although I supported this legislation and sought to have our committee act on H.R. 2629 shortly after it was passed by the House last year, such action has been delayed in response to concerns raised by some administration officials and also by questions about whether some recent uses of the land were in conformance with the restrictions in the existing deed. Finally, as a result of the efforts of many individuals, especially those of the VA's Deputy General Counsel, Robert Coy, who made a site visit to the property and met with university officials about this issue while in Los Angeles recently, the various concerns and questions have been resolved. At the committee's June 27, 1984, hearing, Mr. Coy, in response to my question about his views on the subject of the university's use of the property stated that "for all practical purposes (UCLA is) conforming with the restrictions on the property" and that he was aware of "no further legal issues or restrictions that would impede proceeding with the legislation". Later, on July 11, 1984, the VA's General Counsel, John Murphy, wrote to UCLA Vice Chancellor Elvin Svenson to set forth the agency's view that any concerns about the use being made of the land had been satisfactorily resolved. Thus, Senator WILSON and I are now in a position to urge that this mesure proceed, and hence it is included in the Simpson-Cranston amendment.

Mr. President, I ask unanimous consent that various documents pertaining to this matter—my letters to Chairman SIMPSON urging action on this measure, a letter to me from UCLA Chancellor Charles Young, two letters from Joshua A. Muss, executive director of the Property Review Board, relating to the property, and VA General Counsel Murphy's July 11, 1984, letter to UCLA Vice Chancellor Svenson—be printed in the RECORD.

There being no objection, the letters were ordered to be printed in the RECORD, as follows:

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC, February 9, 1984.

Hon. ALAN K. SIMPSON,
Chairman, Committee on Veterans' Affairs, U.S. Senate, Washington, DC.

DEAR AL: I am writing regarding H.R. 2629, which, as you know, is a measure that was passed by the House on November 8, 1983, and is now pending in our Committee. This legislation, sponsored by my colleague from California, Congressman Beilenson, has the sole, very limited purpose of modifying a restriction on the use of a parcel of land—previously conveyed by the VA to the State of California in 1948—located in West Los Angeles. The land is now occupied by the University of California at Los Angeles.

As far as I am able to determine, this is a noncontroversial measure. If this is indeed the case, in order that the matter may be disposed of in a timely manner, I urge that the members of the Committee be polled and the measure placed on the Senate calendar for action as soon as possible.

Thank you for your continuing cooperation and assistance.

With warm regards,
Cordially,

ALAN CRANSTON,
Ranking Minority Member.

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC, March 7, 1984.

Hon. ALAN K. SIMPSON,
Chairman, Veterans' Affairs Committee, U.S. Senate, Washington, DC.

DEAR AL: In follow up to my February 9, 1984, letter regarding H.R. 2629, please find enclosed a copy of a recent letter I've received from UCLA Chancellor Chuck Young on this subject.

In view of the information in Chancellor Young's letter and his expression of UCLA's strong interest in the enactment of H.R. 2629, I again urge that the members of the Committee be polled on this measure as soon as possible.

Thank you for your continuing cooperation and assistance.

With warm regards,
Cordially,

ALAN CRANSTON,
Ranking Minority Member.

Enclosure.

UNIVERSITY OF CALIFORNIA,
OFFICE OF THE CHANCELLOR,
Los Angeles, CA, February 8, 1984.

Hon. ALAN CRANSTON,
U.S. Senator,
Senate Office Building,
Washington, DC.

DEAR ALAN: H.R. 2629, introduced by Congressman Beilenson, who represents the district in which UCLA is situated, has unanimously passed the House and awaits action in the Senate Committee on Veterans Affairs. This bill is of critical importance to the University, and I urge you to do everything you can to secure its passage.

The bill relates to property adjacent to UCLA and deeded to it by the Veteran's Administration in 1948. This property was given over wholly to UCLA, but with the restriction that any facilities on it had to be for medical research or related purposes.

The only facilities presently on the site are medically-oriented, but the passage of time and changed circumstances make the further construction of major medical facilities on that site not congruent with its optimal use. Any further medical developments are likely to occur closer to the UCLA Medical Center, for obvious reasons.

In any case, H.R. 2629 simply permits UCLA to use the property for cultural and educational purposes in addition to the medical purposes. UCLA's restricted space, and the location of this property next to Westwood Village, make it the ideal site for a number of possible projects that will complete the growth of this campus.

The bill is supported by the Veterans Administration and the Justice Department, but we understand that for some unknown reason the Office of Management and Budget has not responded to a request for a position, and that this fact is troubling some in the majority.

This bill is vital to us, and we would appreciate any help you can provide. A copy of the House Committee report is enclosed.

Sincerely,

CHARLES E. YOUNG,
Chancellor.

PROPERTY REVIEW BOARD,
Washington, DC, November 22, 1983.

Hon. ALAN SIMPSON,
Chairman, Committee on Veterans Affairs, U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: I am writing to you about H.R. 2629 which would modify the reversionary interest of the United States in some 35 acres of property given to U.C.L.A. in 1948. This legislation has been referred to your Committee. I am concerned about this legislative proposal-which in my opinion is completely inconsistent with sound federal property management.

When the Veterans Administration donated the property to the State of California for U.C.L.A. in 1948, it was specified by Congress that the property would be used for medical research. Only on that basis could Congress justify a tranfer of this property fom the holdings of the Veterans Administration. U.C.L.A. agreed and a specific development schedule was proposed. However, U.C.L.A. never completely fulfilled those promises.

Significant portions of the property are undeveloped or used for a public parking lot. These uses of the property are unrelated to medical research or any corollary activity. Apparently, U.C.L.A.'s desire to use this property for some commercial or other non-authorized purpose has led to the introduction of this special legislation.

At our request, the GSA has recently sent a representative to inspect the premises. A copy of this report has been sent to the staff of the Committee on Veterans Affairs. GSA estimates the value of this property to be $280 million.

I expect that this legislation will be recognized by the Senate for what it actually does: It receives U.C.L.A. of its 35-year old obligation. This would set a most unfortunate precedent for other beneficiaries of free federal property transfers who also fail to comply with the terms of the transfer.

I hope that when your Committee considers this proposal you will keep my views in mind. If you or the Committee staff would like to discuss this proposal further, please let me know.

Sincerely,

Joshua A. Muss,
Executive Director.

Enclosure.

INSPECTION TRIP REPORT

Re: 34.88-acre parcel located in West Los Angeles, California, and transferred to the State of California by Public Law 80-726, dated June 19, 1948.

Harold Spady,
Realty Specialist.

On October 3, 1983, I traveled to Los Angeles to review the utilization of the property cited above. On arrival, I visited the site and offer the following observations.

Site Description: The parcel is bounded by Wilshire Boulevard on the south, Veterans Avenue on the west, a row of residences along Strathmore Drive on the north, and an unnamed alley on the east. Approximate dimensions are 662 feet by 2500 feet. The parcel rises to the north and is heavily wooded over the northern two-thirds.

Improvements: There are three permanent university buildings on the parcel, all located on the northern two-thirds of the property. They consist of a Rehabilitation Center, Warren Hall, which is listed as a Biomedical and Environmental Sciences Building, and a stream plant. The only other permanent structure on the parcel is a Red Cross building located immediately to the south of a fire station on Veterans Avenue. The fire station is situation on a 100-foot x 150 foot parcel deeded to the City of Los Angeles for that purpose in 1945. It is assumed that the Red Cross building is on permitted land.

At the northwest corner of the parcel, along Veterans Avenue, site clearance has begun on approximately three acres for a Center for Health Enhancement and a Clinical Pavillion. There are restricted parking lost in the areas of the Rehabilitation Center, Warren Hall, and the Red Cross building. The southerly one-third of the parcel, with the exception of the Red Cross area, has been paved and is used as a staff and student parking lot.

Neighborhood Data: The area south of the parcel across Wilshire boulevard is improved with two high-rise office buildings. The area west of the parcel contains the V.A. cemetery. The area north of the property is improved with a mixture of single-family dwellings and condominiums. The area to the east of the parcel is the Westwood shopping area with approximately six square blocks of commercial buildings. An appraisal of land adjacent to the Federal building at 11000 Wilshire Boulevard was done in May of 1983 and set the land value in the area at $200.00 per square foot.

Observations and Comments: After noting the size of the main parking area, the degree of occupancy at the time of the visit, and the capacity of the improvements which the university has on the parcel, it is obvious that parking is not restricted to staff and students involved in the medical education process at the site. It was further noted that while admission to the lot was restricted until 9:00 a.m. on weekdays, after that time, the lot was available to "visitors." Those with permits utilized a mag-card type entry key while "visitors" could gain entry by depositing $2.00 in a coin box located at the Kinrose Avenue gate.

I discussed the parking with the Assistant Building Manager at 11000 Wilshire Boulevard. He indicated that the lot was heavily used by employees of the shops in Westwood shopping area and their customers. He also stated that a shuttle bus ran between the parking lot and the main university campus to the northeast. Finally, he stated that the lot is open evenings and on the weekends and is usually near capacity, even during the summer months when the university has a much reduced attendance.

Based on my observations and the comments from the Assistant Building Manager, it would appear that the parking area (approximately ten acres) is the only portion of the parcel which is not used exclusively for medical related purposes.

Harold Spady.

Property Review Board,
Washington, DC, March 30, 1984.

Mr. Anthony J. Principi,
Chief Counsel, Staff Director, Senate Committee on Veterans' Affairs, Russell Building, Washington, DC.

Dear Mr. Principi: I am concerned that a letter which I sent to Senator Simpson on November 22, 1983, concerning H.R. 2629 has been misconstrued. The sole purpose of that letter was to provide the Committee with information which I had just received concerning the background and current use of the property. I thought this information would be useful to the Committee in considering the bill.

The letter was not intended to express the Administration's or the Property Review Board's position on the proposed legislation. In rereading the letter in the light of recent events, I realize that it would have been preferable to have omitted the statements of my personal views on this legislation.

Sincerely,

Joshua A. Muss,
Executive Director.

Veterans Administration,
Office of General Counsel,
Washington DC, July 11, 1984.

Mr. Elvin V. Svenson,
Vice Chancellor for Institutional Relations, University of California, Los Angeles, CA.

Dear Mr. Svenson: I believe the information obtained as a result of your recent meeting in Los Angeles with Mr. Robert Coy, and the subsequent action taken by the university as a result thereof, has for all practical purposes eliminated the concern we had with respect to the potential of a non-conforming use by the University of certain portions of the real estate transferred by the United States on June 14, 1948, to the State of California.

As you are aware, concern has been expressed that some of the parking activities may not have been consistent with the restrictions associated with the transfer of the subject property. We now find, however, that some 94 percent of the utilization of the parking facility is associated with University activities. While all of such usage may not be specifically associated with the research and medical center, alternate parking facilities in other areas of the campus are sharing some of the parking needs of the research and medical center personnel. In other words, if we were to force all research and medical center people to park in the parking lot in question, full utilization of that space would probably occur.

An additional concern was the public parking usage which was authorized by the University as a public service where not required by University needs. It is my understanding that you have tightened up this public parking utilization during the day and any such usage must now be considered minimal.

In light of the above, we have concluded that there is substantial conformance with the restrictions associated with the land transfer, and we see no need for further action by the Veterans Administration at this time in connection with the non-conformance issue.

Sincerely yours,

John P. Murphy,
General Counsel.

ACQUISITION OF BUILDINGS FOR STATE HOME FACILITIES

Mr. CRANSTON. Mr. President, included in title 38, United States Code, are two programs of assistance to State veterans' home extended-care facilities which provide care to veterans who are eligible for VA care: A program of per diem payments for care provided to veterans in such facilities; and a program of matching grants for the construction, remodeling, or renovation of State veterans' homes. I strongly support both of these State home programs, which I view as vital adjuncts to the VA's overall efforts. I was very pleased that the Congress last year enacted legislation I proposed to provide an overdue increase in the per diem rates paid under the first program.

Included in the amendment, on behalf of my colleague on the committee from Minnesota [Mr. Boschwitz], is a provision, section 15, addressing the other element of VA assistance to the State home program—the matching grant program. Under current law, the VA is authorized to provide matching grants to States for the construction of new nursing home and domiciliary facilities. It is the VA's view that under current law, such grants cannot be made to States for the purpose of purchasing an existing facility in order to convert it to a State veterans' home facility. This limitation seems unnecessarily restrictive, especially at a time when there is significant interest in expanding the State home program in order to help meet the extended health-care needs of an ever-growing population of older veterans. The provision in the committee amendment would remove this restriction in situations where the purchase and adaptation of a facility would not be more costly than new construction, and I am pleased to support this provision.

SENSE OF THE CONGRESS REGARDING CERTAIN GRACE COMMISSION RECOMMENDATIONS

Mr. President, I am also very pleased that the amendment includes a provision, section 16, offered on behalf of my good friend from Arizona [Mr. DeConcini], myself and Senators Randolph, Matsunaga, Pell, Sarbanes, Heflin, and Burdick, which will put the Congress on record with reference to certain recommendations of the President's Private Sector Survey on Cost Control, the so-called Grace Commission. The Grace Commission recommendations at issue all relate to the VA health-care system, and I believe it is vitally important that the Congress express clearly its continuing, full support of the maintenance of a vital, independent VA health-care system and its concern about the implications of recommendations that could undermine that system.

Mr. President, challenges to the VA health-care system are not new, and the recommendations of the Grace Commission in this area are not unprecedented. As in the case of previous challenges to the integrity of the VA health-care system, the Grace Commission's views reflect little understanding or appreciation of the complexities of the VA system or of the implications of proposals to make sweeping changes in it.

Let me be clear—I do not believe that the VA health-care system is without flaws. But I do not believe the relevant debate is over the question of whether the system should be dismantled or altered in fundamental ways. The only way we can effectively meet our national obligation to provide care to veterans disabled during their service, I am firmly convinced, is through the maintenance of a comprehensive, nationwide VA system such as exists at present. To this end, our amendment essentially points out that the Grace Commission recommendations must be viewed in the context of two provisions of law enacted by Congress—expressly requiring the VA to maintain a "comprehensive, nationwide health-care system for the direct provision of quality health-care services to eligible veterans" and also requiring the VA to operate and maintain not less than 90,000 hospital and nursing home beds—and in view of certain facts that the Grace Commission does not seem to have been aware of or taken into account. The provision concludes by expressing the sense of the Congress that the Grace Commission recommendations must be evaluated in light of the national commitment to the VA health-care system and that no action should be taken on those recommendations without their policy implications having been given careful consideration, in the hearing process, by the Committees on Veterans' Affairs of both Houses.

I congratulate Senator DECONCINI for continuing to pursue the resolution he introduced on April 19, 1984, with the cosponsorship of Senators RANDOLPH, MATSUNAGA, and myself—Senate Resolution 364— relating to the Grace Commission's findings in this area and am very pleased that a provision based on this resolution is included in the floor amendment.

AUTHORITY TO ADJUST RATES OF PAY FOR CERTAIN PSYCHOLOGISTS

Mr. President, another provision in the amendment, section 17, would provide the VA Administrator with new authority to modify the rates of basic pay for certain psychologists working in the VA's Department of Medicine and Surgery—DM&S. This provision, which was included in the amendment at my request on behalf of my good friend from Hawaii [Mr. INOUYE] and Senators MATSUNAGA, RANDOLPH, DECONCINI, and MELCHER, is derived from S. 155, legislation introduced by Senator INOUYE.

Under the provisions in the amendment, the VA Administrator, when necessary for recruitment and retention purposes, would be authorized to modify the rates of basic pay for clinical or counseling psychologists working in DM&S who hold diplomas as diplomates in psychology from an accrediting authority approved by the Administrator. The principal such authority is the American Board of Professional Psychology. These are so-called board-certified psychologists. In order to exercise this authority, the Administrator would have to find that increased rates were needed in order to achieve one or more of the following purposes set forth in current section 4107(g)(2) of title 38: First, to provide rates of pay competitive with the rates paid to such individuals by non-Federal employers in the same labor market; second, to achieve adequate staffing at particular facilities; or, third, to recruit persons with specialized skills.

Mr. President, despite my longstanding support for the profession of psychology and the role of the psychologist as an independent health-care provider, I was unable to support S. 155 as introduced. The primary reasons for my position were twofold: First, I was unaware of any data which suggested that the VA was experiencing difficulties in recruiting or retaining board-certified psychologists, and, second, I was unaware of any reason for singling out psychologists, as proposed in S. 155, from other DM&S health-care professionals employed under title 5, United States Code, to receive additional pay, automatically and across the board, for receiving an advanced degree. The distinguished chairman of our committee [Mr. SIMPSON] likewise was not able to support S. 155 as introduced.

Because of my strong interest in the issue of DM&S staffing and my strong conviction about the important role of psychologists in the VA, however, I pursued the issue of the VA's need for board-certified psychologists and became convinced that there may be a problem in this area. Although the VA is not able at this time to state exactly how many such psychologists would be desirable and appropriate within DM&S, the Acting Chief Medical Director has indicated a clear belief that having more board-certified psychologists in DM&S would improve the overall quality of psychological care provided to eligible veterans. In light of this VA position, I worked closely with Senator INOUYE to develop an approach satisfactory to both of us that would provide the Administrator with increased flexibility to modify rates of base pay on a local, national, or other geographic basis as necessary to attract and retain clinical and counseling psychologists with board certifications. Under the compromise added by the floor amendment, clinical and counseling psychologist rates of pay within the Department of Medicine and Surgery would be placed in the same category as rates of pay for licensed vocational or practical nurses and for certified or registered respiratory therapists, and licensed physical therapists working in DM&S. Last year, in Public Law 98-160, the Congress gave the Administrator broad rate-setting authority with respect to those three title 38 health professionals. I am pleased that we were able to develop this compromise and look forward, if the provision is enacted, to the VA's effective and appropriate utilization of it.

Mr. President, I ask unanimous consent that the text of correspondence I have had with the VA on this issue be printed in the RECORD.

There being no objection, the correspondence was ordered to be printed in the RECORD, as follows:

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC, May 8, 1984.

Dr. DONALD L. CUSTIS,
Chief Medical Director, Veterans' Administration, Washington, DC.

DEAR DON: Recently, a constituent and long-time friend, Dr. Joan Willens, wrote to me regarding S. 155, legislation that would authorize the Administrator of Veterans' Affairs to pay incentive pay to VA psychologists who obtain board certification or who receive an additional advanced degree. You will recall that we have previously corresponded about this measure (see my August 23, 1983, letter to you, your September 12, 1983, response, and follow-up correspondence).

In her letter, Dr. Willens noted that "only 7% of VA psychologists have earned their boards". Without reaching any final judgments on the implications of that statement, I am concerned that the VA's having such a small percentage of board-certified psychologists may raise questions about the overall quality of the VA's psychology program. So that I might have a better understanding of this issue, I would appreciate your responses to the following questions:

1.A. How does the percentage of VA psychologists (separately for clinical and other psychologists) who have obtained board certification compare to the percentages of clinical and other psychologists in the profession as a whole?

B. Please provide the same data as in A, with respect to both clinical and other psychologists, for VA facilities as compared to non-VA hospitals (and separately as compared to community mental health centers).

C. What has been DM&S's experience over the past five fiscal years with respect to the percentage of its psychologists that is board certified?

2. Ideally, how many psychologists positions in DM&S should be filled by psychologists who have obtained board certification?

3. Do you believe that being able to provide additional incentives pay for obtaining board certification would improve the VA's ability to attract and retain psychologists with such qualifications?

4. Would providing special authority to utilize the Government Employees Training Act or comparable VA authority (even though there would be no increase in responsibilities for the participants) to pay for the costs of a VA psychologist obtaining board certification improve the VA's ability to retain a higher quality of clinical psychologists? (In this regard, I note that a provision to grant such authority for nurses was included in section 106(2) of S. 2543 as passed by the Senate on June 5, 1980 (copy enclosed).)

5. In light of the fact that VA psychologists are hired under the authority of title 5, United States Code, has the VA requested the Office of Personnel Management to provide authority for increased pay to psychologists who obtain board certification?

Thank you, Don, for your continuing cooperation and assistance.

With warm regards,

Cordially,

ALAN CRANSTON,
Ranking Minority Member.

Enclosure.

VETERANS ADMINISTRATION,
DEPARTMENT OF MEDICINE
AND SURGERY,
Washington DC, June 20, 1984.

Hon. ALAN CRANSTON,
Ranking Minority Member, Committee on Veterans' Affairs, U.S. Senate, Washington, DC

DEAR SENATOR CRANSTON: Your letter of May 8, 1984, to Donald L. Custis, M.D., asked some specific questions concerning the issue of incentive pay for VA psychologists who obtain board certification. While data are not available for all of the questions you asked, I will attempt to be as comprehensive as possible.

Question 1A. How does the percentage of VA psychologists (separately for clinical and other psychologists) who have obtained board certification compare to the percentages of clinical and other psychologists in the profession as a whole?

Question 1B. Please provide the same data as in A, with respect to both clinical and other psychologists, for VA facilities as compared to non-VA hospitals (and separately as compared to community mental health centers.)

Answer to Questions 1A & 1B: The folowing data are provided as partial answers to these questions. Information concerning non-VA hospital's level of ABPP certified psychologists is not currently available.

Board Certification—Profession as a Whole: The American Psychological Association just completed a study that indicates that 10.4 percent of doctoral level clinical and counseling member psychologists have completed the ABPP certification process.

Board Certification—VA Psychologists: The Association of VA Chief Psychologists just recently completed a study intended, in part, to answer questions raised by the members of the Senate and directed to the Chief Medical Director. This study involved over 75 percent of VA paycologists. The Association has provided the information presented below:

DIPLOMATE STATUS OF CHIEFS OF PSYCHOLOGY

	Number	Percent
ABPP:		
GS-13	1	4.3
GS-14	14	23.3
GS-15	3	18.8
Total	18	18.2
Other boards:		
GS-13	2	8.7
GS-14	5	8.3
GS-15	2	12.5
Total	9	9.1

Number of Diplomates on staff at close of FY 1981: ABPP—59 or (5.6 percent); other boards—18 or (1.7 percent).

Number of Diplomates Hired or Transferred in during FY 1982 and FY 1983: ABPP—4; other boards—18.

VA Staff Psychologists Awarded Diplomates during FY 1982 and FY 1983: ABPP—9; other boards—15.

VA Staff Psychologists with Diplomates who Left Stations during FY 1982 and FY 1983: Retired—ABPP, 7; other boards, 1. Resigned—ABPP, 5; other boards, 2. Transferred Out— ABPP, 0; other boards, 1.

Question 1C. What has been DM&S' experience over the past five years with respect to the percentage of its psychologists that are board certified?

Answer. VACO Mental Health and Behavioral Sciences Service indicates that slightly less than 7 percent of clinical and counseling psychologists in the VA have the ABPP. This has remained substantially unchanged over the past five years: 1976—110 Diplomates; 1979—79 Diplomates; 1982—89 Diplomates.

Question 2. Ideally, how many psychologist positions in DM&S should be filled by psychologists who have obtained board certification?

Answer. Ideally, if available, it would be desirable if approximately 1100 of the current 1435 psychologist positions in DM&S represented the highest level of comprehensive psychological functioning in patient care areas. The remaining positions would be occupied by entry-level psychologists requiring greater supervision and expertise.

Question 3. Do you believe that being able to provide additional incentive pay for obtaining board certification would improve the VA's ability to attract and retain psychologists with such qualifications?

Answer. Yes. It is not clear, however, what type of incentive pay would yield the most cost effective results for the desired outcome of encouraging present staff to pursue this goal and to attract and retain individuals with such qualifications. DM&S will continue to study the alternatives.

The following data from the above cited study by the Association of VA Chief Psychologists indicate that various options could have various impacts. For example:

Would you take the ABPP Examination if offered a $2,500 per year bonus? Yes, 56.6 percent; no, 24.6 percent; do not know, 18.8 percent.

Would you take the ABPP Examination if offered a one-time award of $1,000—$2,000? Yes, 24.7 percent; no, 55.3 percent; do not know, 20.0 percent.

Would these methods of recognition help significantly in retaining and recruiting competent staff? Yes, 48.5 percent; no, 33.0 percent; do not know, 18.5.

It should be noted that some VA psychologists are not eligible to take boards, and that others are too senior in their careers to see the value of the extra study, preparation and expense involved in obtaining boards. Although the goal of having staff with the highest credentials is laudable, it is not yet clear what incentive would achieve that goal. Additionally, it is recognized that use of other authorities such as those granted by PL 96-330 and PL 98-160 may contribute to the VA's ability to attract the most qualified psychologists.

Question 4. Would providing special authority to utilize the Government Employees Training Act or comparable VA authority (even though there would be no increase in responsibilities for the participants) to pay for the costs of a VA psychologist obtaining board certification improve VA's ability to retain a higher quality of clinical psychologists? (In this regard, I note that a provision to grant such authority for nurses was included in section 106(2) of S. 2543 as passed by the Senate on June 5, 1980.)

Answer. Undoubtedly a greater number of psychologists would pursue board certification if they would not have to absorb the cost. However, it is unclear whether such an authority would impact on retention. The provision of S. 2543 that you referenced provided for a guaranteed "pay back" in the form of years of service in return for training support to a nurse pursuing a degree. It is questionable to what extent such a provision for "pay back" would be reasonable in the case of psychologists pursuing board certification. Further, many occupations recognize certifying boards and encourage this form of credentialling. In view of this, DM&S would have to consider the impact and potential costliness if such an authority as you suggest were to apply to a number of occupational groups.

Question 5. In light of the fact that VA psychologists are hired under the authority of title 5, United States Code, has the VA requested the Office of Personnel Management to provide authority for increased pay to psychologists who obtain board certification?

Answer. The VA has not requested increased pay for psychologists who obtain board certification because supportive data has not been fully accumulated. VA's authority to approve special rates for direct health care occupations has not been fully implemented. DM&S has not had the opportunity to use the authority for appropriate occupational situations. The Department is aware of the need to study various alternatives to determine which would be most effective and least costly in accomplishing the objective of insuring the VA's employment of well-qualified psychologists to provide quality patient care.

I hope that this information will be of value to you.

Sincerely,

JOHN A. GRONVALL, M.D.,
Acting Chief Medical Director.

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC, July 2, 1984.

Dr. JOHN A. GRONVALL,
Acting Cheif Medical Director, Veterans' Administration, Washington, DC.

DEAR JOHN: Thank you for your June 20, 1984, response to my May 8, 1984, letter regarding various issues related to psychologists employed in DM&S. I very much appreciated receiving your detailed answers.

So that I might have a better understanding of the agency's overall position on these issues and on some specific points in your reply, I have a few follow-up questions to some of the answers in your letter. Specifically, I am interested in your answers to the following questions:

1. In answer to question 1B, you note, "Information concerning non-VA hospitals' level of ABPP certified psychologists is not currently available."

A. Do you anticipate that this information will be available in the near future?

B. Is there a basis for estimating whether the level of psychologists with ABPP certification in non-VA hospitals is higher or lower than the level in the profession as a whole (noted as 10.4% in your letter)?

2. In your answer to question 2, you indicated that "it would be desirable if approximately 1100 of the current 1435 psychologist positions in DM&S represented the highest level of comprehensive psychological functioning in patient care areas."

A. Approximately how many of the psychologists in these 1435 positions at present represent that "highest level", and is that term a reference to board certification?

B. Of the psychologists presently in those positions, how many do you believe (i) are eligible to take the ABPP examination; (ii) would actually take the examination, if a salary incentive existed to do so; and (iii) would likely pass the examination and thus obtain board certification?

3. In your answer to question 3, you indicated that "it is recognized that use of other authorities such as those granted by P.L. 96-330 and P.L. 98-160 may contribute to the VA's ability to attract the most qualified psychologists." I agree with this statement and would appreciate further information on how the agency believes such authorities might be used and the timetable for any such action.

4. In your answer to questions 1A and B, you indicated that, at the close of FY 1981, 5.6 percent of VA staff psychologists had ABPP certification. In your answer to question 1C, you indicated that "slightly less than 7% of clinical and counseling psychologists in the VA have the ABPP." What is the relationship between these two percentages?

Thank you, John, for your continuing assistance and cooperation. I would very much appreciate a reply by July 20.

With warm regards,

Cordially,

ALAN CRANSTON,
Ranking Minority Member.

PROGRAM GUIDE ON ALZHEIMER'S DISEASE

Mr. CRANSTON. Mr. President, the Simpson-Cranston amendment also includes a provision offered on behalf of my good friend from Ohio [Mr. METZENBAUM] and derived from S. 2220, legislation he introduced earlier this year relating to VA care for veterans suffering from Alzheimer's disease and related neurological diseases. Although Chairman SIMPSON and I were unable to support S. 2220 as introduced, I am pleased, in light of Senator METZENBAUM'S, as well as my own, strong personal interest in this issue, that we were able to work with him to develop a provision acceptable to all of us which is now included in the amendment.

Mr. President, the provision in the amendment would require the Administrator of Veterans' Affairs, within 180 days of the date of the enactment of this measure, to disseminate to appropriate VA health-care facilities and submit to the Committees on Veterans' Affairs in both Houses a program guide on Alzheimer's disease and related neurological diseases. Such a program guide, which has been under development by the VA for a number of years, would be required to clarify VA policy regarding the authorization and provision of treatment, including diagnosis, information, outpatient services, hospital care, and nursing home care, of veterans who are eligible for such services under title 38, United States Code, and who are suffering from Alzheimer's disease and related neurological diseases. It has been contended by some who are active in working with Alzheimer's victims that there is some confusion at the local VA facility level about agency policy in this regard. This program guide should help end any such confusion and should provide a basis for more widespread understanding of VA policy in this area.

Mr. President, I want to make two additional points on which our acceptance of this provision is premised. First, this provision does not provide any new authority to furnish, or new eligibility for, health-care services from the VA. Second, the provision also does not mandate the content of the agency policies that would be stated in the guide with respect to the VA's use of its existing statutory authority to provide health-care services with respect to Alzheimer's disease. In essence, the amendment would require the VA to complete work on and disseminate a program guide that has been under development for *far* too long.

Mr. President, I ask unanimous consent that a copy of a November 9, 1982, letter to me from the VA's then Chief Medical Director, Dr. Donald Custis, which discusses the program guide and which was in response to an inquiry I made on behalf of Ms. Joy Glenner, a constituent of mine from San Diego who is very active on matters relating to Alzheimer's disease, be printed in the RECORD.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

VETERANS ADMINISTRATION,
DEPARTMENT OF MEDICINE
AND SURGERY,
Washington, DC, November 9, 1982.

Hon. ALAN CRANSTON,
Ranking Minority Member, Committee on Veterans' Affairs, U.S. Senate, Washington, DC.

DEAR SENATOR CRANSTON: Thank you for forwarding the inquiry of your constituent Mrs. Joy Glenner regarding VA guidelines for treating veterans with Alzheimer's Disease. Mrs. Glenner's letter is a moving statement regarding the difficulties faced by patients with this disease and their families.

Mrs. Glenner correctly points out that there is a lack of uniformity in the approach to diagnosis and treatment of dementia in both the private sector and in public medical care systems such as the VA. The medical responsibility for the diagnosis and management of this disease is determined by medical staff at our VA medical centers in accordance with the needs of the patients and the availability of resources to the responsible medical centers. Alzheimer's Disease is considered a nonservice-connected disability. A VA Central Office task group is in the process of developing a program guide to assist medical staff in our hospitals to improve the diagnosis and management of Alzheimer's disease and to help pool resources and talents as to better meet patient needs. Educational activities for staff are being conducted on a routine basis.

The VA is conducting research directed to the causes and improved management of this disease at five of our Geriatric Research Educational and Clinical Centers (Bedford/Boston, MA, Minneapolis, MN, Palo Alto, CA, Sepulveda, CA and Seattle, WA) as well as numerous individual medical centers such as the Bronx VAMC. There are no plans to mandate the creation of Alzheimer's research centers in the VA at this time. However, where our medical centers develop expertise in treating this disease, and where patient care needs dictate, it is possible for them to obtain educational and research funds through existing mechanisms.

Management of Alzheimer's disease requires cooperation between professional staff and the family of the patient. Many of our staff are active participants in chapters of Alzheimer's and Related Disorders Association and VA staff at Bedford, MA have helped establish chapters in the community as well as for patients in the VA hospitals.

I appreciate the concern of your constituent for veterans with Alzheimer's Disease.

Sincerely,

DONALD L. CUSTIS, M.D.,
Chief Medical Director.

VA FACILITY NAMINGS

Mr. CRANSTON. Finally, Mr. President, I want to make mention of the amendment provisions for the naming of two VA Medical Centers.

The first, offered by Senators KASTEN and PROXMIRE, would name the VAMC in Milwaukee, WI, after the late Congressman Clement G. Zablocki of Wisconsin, the very distinguished and sorely missed chairman of the House Committee on Foreign Affairs. The second, offered by Senators SASSER and BAKER, would name the VAMC in Murfreesboro, TN, in honor of Sgt. Alvin C. York, the renowned World War I hero and Medal of Honor winner.

Mr. President, as members may know, the Committee on Veterans' Affairs has a committee rule with respect to its policy regarding the naming of VA Medical Centers. Both of these namings meet all of the Committee's criteria as they were amended at a committee meeting on July 25, 1984.

CONCLUSION

Mr. President, as always, it has been a great pleasure to work with the chairman [Mr. SIMPSON] and all the members of the committee in the development of legislation to meet important needs of the Nation's veterans.

This bill, as it is before the Senate today, is the result of true bipartisan effort—the type of effort that we on the Veterans' Affairs Committee always strive to put forth. I want to note the hard work of, and to thank, the committee staff members who worked on this legislation: Cindy Alpert, Vic Raymond, Tony Principi, and Julie Susman, on the majority staff; James MacRae who so ably provides editorial support to the committee; and, on the minority staff, Bill Brew, Katy Brudick, Ed Scott, Jon Steinberg, Charlotte Hughes, and Ingrid Post.

I believe S. 2514 as reported and amended is a well-balanced, fully appropriate measure that, if enacted, will be of substantial help to the VA in seeking to fulfill its health-care mission. It has the unanimous support of the members of the Veterans' Affairs Committee and has wide support among the veterans' service organizations. I urge my colleagues to give this measure their full support.

Mr. BAKER. Mr. President, I am proud to support the legislation which will name the Veterans' Administration Medical Center in Murfreesboro, TN, in honor of the late Sgt. Alvin C. York.

For his outstanding combat heroism during World War I, Sergeant York was awarded the Congressional Medal of Honor, the French Croix de Guerre, and the Tennessee Medal for Valor. Sergeant York is one of Tennessee's most prominent heroes and an illustrious veteran all Americans can admire. The fine Murfreesboro medical facility will provide an appropriate and long overdue memorial to Sergeant York and all brave veterans who have given their talents in the defense of our Republic and the freedoms we cherish.

Mr. THURMOND. Mr. President, I rise in support of S. 2514, the Veterans' Administration Health Care Amendments of 1984.

The chairman of the Senate Veterans' Affairs Committee, Senator SIMPSON, and the ranking minority member, Senator CRANSTON, both are to be commended for their fine work on this legislation.

Mr. President, I believe that S. 2514, which received the unanimous approval of the Senate Veterans' Affairs Committee on May 9, 1984, is meritorious legislation containing many significant provisions that will maintain and improve the quality of health care provided to our Nation's deserving veterans. Our country owes a great debt to its veterans, and we have an obligation to ensure that the Veterans' Administration is always able to meet the health care needs of eligible veterans.

Mr. President, I am particularly pleased that S. 2514 contains a provision which would improve the health care provided to veterans suffering from "Post-Traumatic Stress Disorder" [PTSD] through the establishment of a Special Committee for PTSD. This special committee would assist the Chief Medical Director of the Veterans' Administration in developing policies, providing guidance and coordinating care for the treatment of veterans with this service-connected disorder. I am also pleased that this provision would require the Veterans' Administration to establish a National Center for PTSD for the purpose of conducting research and training of health care personnel. In addition, this national center would serve the important function of coordinating the exchange of information pertaining to PTSD among all Federal programs involved in PTSD research.

Mr. President, S. 2514 also contains a provision which requires the Veterans' Administration to report to Congress on the kinds of care provided for the terminally ill and the chronically ill. I believe it is most appropriate that we examine compassionate alternative means of providing care for terminally ill veterans. At a time when many of our Nation's veterans are reaching the age of 65, we must work to ensure that our older veterans are provided with adequate health care.

Mr. President, I therefore support this legislation and commend it to my colleagues.

Mr. MITCHELL. Mr. President, I rise today to support the passage of S. 2514, the "Veterans' Administration Health Care Amendments of 1984," which is before the Senate at this time. The many excellent provisions which are included in this legislation have been described in detail by the distinguished chairman of the Veterans' Affairs Committee, Senator SIMPSON, and the distinguished ranking member, Senator CRANSTON, so that I don't feel it is necessary for me to discuss most provisions of this bill at length.

I would like to take several minutes, however, to discuss in some detail section 15 of the committee bill as reported by the Veterans' Affairs Committee on May 11, 1984. Section 15 would provide for a study and report on veterans eligible for VA health-care services who reside in areas remote from existing VA medical care facilities and a subsequent report on a possible experimental program to furnish care to the veteran in such areas.

The issue of health-care for rural, geographically remote veterans is one that has held great interest for me for as long as I have been a Member of the Senate. Over 150,000 veterans reside in my State of Maine; according to 1980 Census Bureau figures, 53 percent of all veterans in Maine live in rural areas. And in Maine, statistics clearly demonstrate that rural veterans utilize VA medical facilities significantly less than nonrural veterans.

Recognizing that, I introduced legislation early in this Congress, which would require the Administrator to establish an experimental program to determine the feasibility of furnishing diagnostic services to veterans living in certain areas of Maine. My legislation, S. 253, was the subject of hearings by the Veterans' Affairs Committee on July 13, 1983.

Testimony from that hearing and subsequent information reinforce what is already known about problems facing veterans in acquiring VA health-care in rural areas due to travel distances, adverse weather conditions and the capacity of VA facilities to meet veterans' needs. What I believe those hearings most significantly demonstrated was: First, the lack of reliable data about the location, number, and distribution of veterans in this country and their utilization of VA health-care facilities based on their distance from those facilities; and second, the absence of any creative, concerted, centralized effort by the VA to address, much less improve, its health-care service delivery to this country's geographically remote veteran population.

It is for those reasons that I introduced an amendment during committee markup of S. 2514, on May 9, 1984, to require a VA-study of eligible veterans residing in areas remote from VA health-care facilities and such veterans' use of VA health care. In carrying out the mandated study, the Administrator will develop statistics on the numbers of eligible veterans living various distances from VA facilities and their utilization of VA health-care services during fiscal year 1985. The Administrator will be required to submit to the House and Senate Committees on Veterans' Affairs a full report on the study by January 1, 1986. That report would include the Administrator's findings on the extent of the need for the VA to increase health-care services in rural areas.

Following that, the Administrator would be required to submit to those same committees by July 1, 1986, a report describing in detail an experimental national program that could be carried out in five locations to demonstrate alternative approaches that could be used by the VA to provide health-care services to eligible veterans in remote areas and the Administrator's recommendations as to whether any such projects should be carried out.

I firmly believe that when the VA documents, on a national basis, the utilization of VA health-care services by rural veterans the figures will show what our experience in Maine has already shown. That rural veterans are not using VA health-care services and facilities nearly to the extent of nonrural veterans. And from that documentation will come the realization that new, creative, alternative methods of delivering VA health-care to rural veterans must be instituted in a centrally directed effort by the Administrator if that discrepency is to be changed.

Mr. President before I close, I want to express my gratitude to both the chairman and ranking member of the Veterans' Affairs Committee for their efforts to work with me on this issue, to schedule hearings for my original bill, S. 253, and the topic of rural health-care for America's veterans during the committee's consideration of veterans health-care issues.

Mr. PRESSLER. Mr. President, I support the proposal to allow the Veteran's Administration to extend State home grant moneys to individual States for the acquisition of already-existing facilities. This would apply specifically to domiciliary and nursing home facilities. I urge my colleagues to support this cost-saving measure and I commend the Senate Veterans' Affairs Committee—and in particular, Senators BOSCHWITZ, SIMPSON, and CRANSTON—for bringing this legislation before the Senate today.

Presently, the VA grant moneys that are allocated to States for State home construction must be used for the building of new State homes or the modernization of existing ones. These grants make up approximately 65 percent of State home construction costs. This inflexible guideline means that an individual State is precluded from acquiring a presently unused private facility which might well meet its needs. This is inefficient management of limited Federal and State funds.

At this point, I would like to point out that the new plan would be executed with close VA supervision. Acquired facilities would initially have to meet certain health and safety standards. Also, at the time of acquisition, reasonable assurances must be made that the purchase cost, along with any remodeling or alteration, must not be more than the cost of constructing a new facility. In most cases, these costs should be much less.

It seems apparent that this legislation would do two very beneficial things. First, it would save money by cutting construction costs. Second, and equally significant, it would allow States that need to expand their State home facilities to do so more quickly. This should benefit elderly veterans who are in need of State home care.

All of us know that meeting the health care needs of our veterans will become increasingly more difficult in the years ahead. It is estimated that our 65 and older veterans—now numbering approximately 4 million—will reach 8 million by 1990 and 12 million by the turn of the century. We can expect that rising nursing home and related service costs in the private sector will force more and more elderly veterans to turn to VA and State home facilities. It goes without saying that the 103 nursing homes and 16 veterans homes that are presently staffed by the VA will not meet our needs.

Therefore, State home facilities are likely to come in increasing demand. The measure before us now is a responsible way of confronting this problem. This is not to say that it will do so on its own. However, it is a step in the right direction.

Mr. PRESSLER. Mr. President, I am pleased to act as a cosponsor of this amendment providing assistance to our veterans suffering from Alzheimer's disease. Alzheimer's disease is a form of dementia. It includes memory loss and confusion. It was once dismissed as senility, part of the aging process. Scientists have discovered that there are physical causes for the disease. Many questions remain unanswered but we are making headway.

As we await treatment answers we must do all we can to assist the families of those suffering from this tragic disease. The Alzheimer's Disease and Related Disorders Association has done a tremendous job of organizing support groups for the families and friends. This assists with the emotional problem but cannot be an answer to the financial difficulties. We must help ease that burden.

With the passage of this amendment, we would undertake a national policy of counseling, treatment and information programs for our veterans.

We also would provide a new category of eligibility for benefits. This addition would assist Alzheimer's victims in meeting costs of hospital and nursing home care.

As a member of the Senate Aging Committee and a Vietnam veteran, I have long been concerned with the needs of our veterans population. By the turn of the century an estimated 12 million veterans will be over 65 years old. I believe it is important to realize the gravity of this situation. At present, the Veterans' Administration operates 172 hospitals and 226 outpatient clinics. These facilities are presently at 95 percent of capacity. The VA must carefully plan for the new influx. With the passage of this amendment we will begin the coordination that is needed for the veterans community to deal with the tragedy of Alzheimer's disease. The health care costs for victims can drive the family into bankruptcy. Those of us in Congress must deal with some difficult health care questions. We are taking a big step forward today. I am pleased to be a part of this effort.

Mr. BOSCHWITZ. Mr. President, on May 24 of this year, I introduced legislation, S. 2715, that takes a simple straightforward step in improving veterans nursing home care.

My legislation, which was cosponsored by my friend from South Dakota, Senator PRESSLER, changes the Veterans' Administration's State Home Program to allow States to use their construction grant money to acquire and renovate already existing facilities.

The State Home Program now pays per diem rates for the care of the vets in the homes, and provides grants for up to 65 percent of the cost for construction or modernization of extended care facilities. This includes both domiciliary and nursing home care. It is a well-run, cost-effective program and my legislation will only improve it by giving States the flexibility to acquire—at much lower cost—an existing nursing home, rather than go to the expense of building a new one from scratch.

Today, I am offering my legislation as an amendment to the health bill because I feel it is very important and timely to make these needed improvements in veterans nursing home care.

Mr. President, in the next 5 years the makeup of this Nation's veteran population will continue its steady shift. By 1990, this country's over-65 population will change such that 50 percent of the over-65 males will be veterans. And, by the end of the century, the current over-65 vet population of 4 million will grow to almost 9 million. Clearly, this is both an opportunity and a challenge for the veterans' health care system.

Currently, in Minnesota, 20 percent of our elderly are veterans and already 50 percent of the males over 65 are vets. We are also facing an incredible increase in the number of veterans over age 80—the group most likely to need and use long-term care facilities—from 5,500 now to over 600,000 by the year 2000.

Most people who know the circumstances realize that the VA does not have the resources to build the number of nursing homes it will need to handle the aging World War II veterans. We also realize that, even if the resources were available, a short-term solution of major nursing home construction would only leave us with a large number of unused facilities 20 to 30 years down the road. Therefore, we must find a wiser and more prudent way to provide care for these veterans.

I believe this amendment is one such prudent solution. I hope my colleagues will join me in supporting it.

Mr. DENTON. Mr President, the legislation before us today is an important step in providing improved health care to the veterans who have served our country and given of themselves in defense of our national freedom and security. It also exemplifies the dedication of the Veterans' Affairs Committee staff and the cooperation that is necessary on both sides of the aisle of produce legislation that best serves the interests of America's veterans.

The items contained in the legislation are beneficial to the majority of veterans in need of health care, and they provide a needed adjustment of and enhancement to current law. Provisions such as pilot programs for alcohol and drug rehabilitation, telecaptioning television decoders for the deaf, and automobile adaptive equipment for the disabled are necessary to the health and well-being of our veterans.

In addition, the legislation provides for several reports to facilitate the study of problems peculiar to veterans and to assist us in our future legislative efforts. Among the reports are one on community referral coordination by VA facilities in order to assist veterans seek help outside the facility; one on programs that provide for hospice or related health care for terminally ill patients; and one on readjustment counseling for active duty military personnel who served in Vietnam, who have been involved in other areas of hostile activity, or who have been held as prisoners of war.

I am pleased to support legislation that gives attention to recurrent problems among the veterans population.

Thank you, Mr. President.

Mr. DeCONCINI. Mr. President, I would like to express my strong support for the Veterans' Administration Health Care Amendments of 1984, S. 2514, and the committee amendment thereto. The distinguished chairman of the Veterans' Affairs Committee, Senator SIMPSON, and the extremely able ranking minority member, Senator CRANSTON, have crafted an outstanding bill which will significantly improve, enhance, and expand health care opportunities for our Nation's veterans.

I am particularly pleased that the committee amendment to S. 2514 includes a sense of the Congress resolution relating to certain recommendations made by the Grace Commission on VA health care. After reviewing the Grace Commission's recommendations early this year, I concluded that a number of them had serious policy implications which, if adopted, would have had the effect of eliminating a comprehensive and independent health care system within the Veterans' Administration.

On April 9, 1984, I introduced Senate Resolution 364, a resolution expressing the sense of the Senate that certain specific recommendations of the Grace Commission relating to VA health care be rejected as a matter of national policy. The distinguished ranking minority member of the Senate Veterans' Affairs Committee, Senator CRANSTON, and my colleagues on that committee, Senators RANDOLPH and MATSUNAGA, joined me in introducing that resolution. Subsequently, Senators PELL, SARBANES, BURDICK, and HEFLIN added their names as cosponsors of Senate Resolution 364 and they wish to be cosponsors of provision 16 in the committee amendment relating to the Grace Commission.

The provision included in the committee amendment relating to the Grace Commission's VA health care recommendations represents a compromise among Senators SIMPSON, CRANSTON, and myself. I am pleased that we were able to reach agreement on this issue and believe the sense of Congrress resolution contained in the committee amendment achieves the result I intended when I introduced Senate Resolution 364.

The Grace Commission's VA health care recommendations which were of particular concern to me and which are addressed in the sense of Congress resolution are as follows:

First, that funds for construction of Veterans' Administration hospitals not already under contract be deleted from the Veterans' Administration budget, that bids be invited from private hospital management companies to lease hospital facilities to the Veterans' Administration under long-term contracts, and that such facilities be managed by private companies under short-term contracts.

Second, that the Veterans' Administration eliminate such number of Veterans' Administration hospital beds as is necessary to achieve an 80-percent occupancy rate for such beds.

Third, that the Veterans' Administration consider converting some underutilized acute health-care facilities to extended health-care facilities and phasing out old hospital facilities which may be in need of replacement or significant reconstruction.

It was my view that these recommendations posed a threat to the integrity of the VA health care system and were inconsistent with two provisions of existing law; namely, the requirement that the VA maintain a "comprehensive, nationwide health care system for the direct provision of quality health care services to eligible veterans," and the requirement that the VA operate and maintain not less than 90,000 hospital and nursing home beds.

I think all my colleagues would agree that adoption of the aforementioned Grace Commission's recommendations would represent a fundamental change in the way VA health care services have been traditionally delivered to veterans and that they ought not to be implemented without thorough congressional review. That is exactly what the sense of Congress resolution concludes. It states that no action to implement these recommendations should be taken without their policy implications having first been given full and careful consideration, after appropriate hearings, by the Committees on Veterans' Affairs of the House of Representatives and the Senate.

I hope adoption of this amendment will reassure veterans that this body remains committed to an independent, quality health care system within the Veterans' Administration.

Again, I thank Senators SIMPSON and CRANSTON for including the sense of Congress resolution in this bill.

Mr. COHEN. Mr. President, I rise in support of S. 2514 and to commend my colleagues who sit on the Committee on Veterans' Affairs for their continued, strong support of programs of benefit to our Nation's veterans.

It is all too easy for us to forget the countless sacrifices that those veterans who have served our country, both in time of war and peace, have made in order to preserve this remarkable society in which we are so privileged to live.

The work of the Committee on Veterans' Affairs reminds all of us of the debt that we owe to our veterans. The far-reaching measures that are contained in the Veterans' Administration Health Care Amendments of 1984, which are now before us, represent a substantial, if only a partial, repayment of that debt.

More specifically, Mr. President, I want to extend my gratitude to Senator SIMPSON and Senator CRANSTON, and particularly to Senator MITCHELL, for their cooperation and diligence in developing section 15 of this bill—a section that represents an important first step toward improving the Veterans' Administration's delivery of health care services to eligible veterans who live in remote areas of the country.

Section 15 of S. 2514 gives congressional recognition to the fact that millions of veterans, who are eligible for health care services from existing Veterans' Administration facilities, reside in areas of the country that are geographically remote from these facilities. Recognition is also given to the fact that this geographical disadvantage keeps these veterans from obtaining necessary health-care services from the VA in many, many cases.

Because the Veterans' Administration has not begun to focus on this widespread problem—a problem which impedes the delivery of VA health-care services to eligible rural veterans—this bill requires the Administrator of Veterans' Affairs to begin to develop information about rural veterans so that alternative approaches to provide adequate services to these veterans can be developed.

In time, the Administrator is to recommend a pilot program to be carried out in five remote areas of the country to demonstrate the feasibility of alternatives to the current, inequitable system.

Because the need for alternative VA health-care services for rural veterans has been brought to the attention of the Congress by the veterans in Aroostook County, ME—where veterans must travel 400 or 500 miles round trip for care at the only VA hospital and outpatient clinic in Maine—it is my intention to work to create one of these pilot programs in Aroostook County.

My involvement in the issue of rural veterans' health care in Aroostook County dates back many years, to my service in the House of Representatives. In 1979, my first year in the Senate, the Hayward-Frazier Post of the Veterans of Foreign Wars, in Presque Isle, ME, first petitioned the Veterans' Administration for the establishment of an outpatient clinic in Aroostook County. Because the VA believed that it did not have the available resources to meet the needs of those rural veterans, as well as others in Maine and across the country, the request was denied.

Subsequent to that decision, the Aroostook County Veterans Medical Facility Corp. was formed in January of 1980. It has worked long and hard over the past 4 years for the establishment of a diagnostic-care facility in Aroostook County. A year ago, corporation officials were successful in setting up, in conjunction with the VA Medical Center at Togus, ME, a followup care program at the Cary Medical Center in Caribou. Although the VA has canceled this program, a similar followup care alternative for Aroostook County veterans is again in place.

Senator MITCHELL's bill, S. 523, also sought to establish a diagnostic-care facility in Aroostook County in order to meet those veterans continuing needs.

Although much time and effort has gone into trying to force the Veterans' Administration to consider the special circumstances of the rural veteran, we have been blocked at every turn.

Mr. President, although the needs of Maine's 55,000 rural veterans are significant and demand attention, they are by no means unique. Millions of veterans in others rural areas of the country also face the same difficulties that are imposed by time, distance, adverse weather conditions, and the lack of public transportation. These impositions are a special burden upon aged veterans, who, in many instances, may simply be unable to make any long journey.

This is a national problem and I am encouraged that the Committee on Veterans' Affairs also perceives this issue in this light. In my opinion, only by establishing a national system that would be of benefit to all rural veterans can the veterans of Aroostook County, and other rural veterans in Maine, enjoy consistent and accessible extended VA health care. The need for this care is acute in Maine, and I look forward to continuing to work with the committee and the Veterans' Administration in order to expedite the implementation of such a national system that will ultimately be of benefit to Maine's rural veterans.

Mr. METZENBAUM. Mr. President, today Senators MELCHER, DIXON, HAWKINS, PRESSLER, BINGAMAN, LEAHY, D'AMATO, and HEINZ join me as cosponsors of an amendment which I have offered to this measure that will create a clear national policy directive from the Veterans' Administration regarding the treatment and care of veterans who have been stricken with Alzheimer's disease. I wish to commend the Committee on Veterans' Affairs and, in particular, the distinguished committee chairman, Senator SIMPSON, and the ranking minority member, Senator CRANSTON, for their hard work on this issue and on all matters pertaining to the health and well-being of our Nation's veterans.

Alzheimer's disease, Mr. President, is one of the most serious medical problems we face today.

As many as 4 million people in this country are afflicted by Alzheimer's.

This cruel disease kills 120,000 Americans per year.

It is responsible for an estimated 50 percent of nursing home admissions. Annual medical expenditures for the treatment of Alzheimer's comes to $26 billion.

As our population ages, the statistics will worsen.

But in spite of the growing problem of Alzheimer's disease, it is a fact that the VA hospital system has no national policy at present with regard to veterans suffering from this ailment. Treatment, hospitalization, nursing home care—all of these are available only at the discretion of individual VA hospital directors.

What is the result? The result, Mr. President, is a crazy quilt pattern of services. Some VA hospital directors choose to accept Alzhemier's patients. Those are the lucky ones—and theirs are the lucky families.

But according to the Alzheimer's disease and related disorders association, many veterans are unable to obtain care for Alzheimer's at VA institutions.

Our amendment is intended to do just one thing—to clarify VA policy on Alzheimer's patients. The amendment states simply that the VA produce a program guide which will end any ambiguity regarding the authorization and provision of treatment for veterans suffering from Alzheimer's disease and related neurological diseases.

Mr. President, the devastating statistics I have cited about Alzheimer's disease cannot begin to tell the whole story. The millions of victims, the thousands of deaths, the billions of dollars—none of these numbers carry with them a sense of the human suffering caused by this terrible disease.

As an Alzheimer's victim slowly disintegrates, the collective spirit of his or her loved ones also crumbles. Alzheimer's disease bankrupts families—financially and emotionally.

I am pleased that the Senate has recognized the serious and urgent nature of this problem. In the past year, we have passed legislation to encourage research that may ultimately help make the lives of the victims and their families more livable. I would also like to commend the distinguished Congresswoman from Maine, OLYMPIA SNOWE, who has introduced similar legislation on the House side and who has a longstanding commitment to the defeat of Alzheimer's disease.

Mr. President, this provision is another important step in the direction of coping with a national problem that cannot be ignored.

I urge my colleagues to support this amendment.

Mr. INOUYE. Mr. President, I am

most pleased that my colleagues on the Veterans' Affairs Committee have agreed that the time has come to recognize and to provide financial incentives to those psychologists in the Veterans' Administration [VA] who have demonstrated exceptional expertise by obtaining national board certification.

My proposal, which has now been incorporated into the larger VA Health Care Act, essentially treats VA psychologists in a manner compatible with their medical colleagues. My original proposal would also have provided the Administrator of the Veterans' Administration with additional authority to provide similar financial incentives for those psychologists who obtained additional advanced educational expertise, such as a master's in public health [MPH], which the Administrator feels is in the best interest of the VA. With our ever-aging veteran population, additional training in gerontology at a school of public health would be advantageous. By mutual agreement, however, that portion of my original proposal (S. 155) has been deleted at this time. However, I look forward to testifying before the Senate Veterans' Affairs Committee on this and related issues next legislative session.

In my judgment, we must continue to ensure that our Nation's veterans will receive the highest quality health care services possible.

Mr. WILSON. Mr. President, I rise today in support of the amendment which would direct the Administrator of Veterans' Administration to modify the reversionary interest of the United States in certain lands previously conveyed to the State of California for the use of the University of California. The text of this amendment is identical to a bill, H.R. 2629, introduced by my distinguished colleague from the other body, Mr. BEILENSON of Los Angeles, which was passed unanimously on the floor of the House last November 8. The amendment also enjoys the support of the Veterans' Administration, the Department of Justice, and the Office of Management and Budget.

This is a simple amendment designed to allow the University of California to make better use of a 35-acre parcel of land originally conveyed by the Veterans' Administration in 1948. At that time, conditions were placed on the deed transfer requiring that the property be used for medical research or related purposes only. This legislation, Mr. President, would allow this land to be used for cultural and educational purposes as well as medical. As in the case of the original law granting the property to UCLA, the amendment provides that the property shall revert to the United States if it ceases to be used for the purposes specified by it.

Much has changed on the campus of UCLA since 1948. Its world renowned medical center is located much closer to the heart of campus, a good distance from the property in question. While the only facilities presently on the site are medically oriented, the passage of time and changed circumstances make the further construction of major medical facilities on this site incongruous with its optimal use and extremely unlikely. Additionally, Mr. President, the lack of space on the UCLA campus, and the location of this property next to Westwood Village—a fast growing commercial and cultural mecca—make this property the ideal site for a number of possible projects that will complete the growth of the campus.

Mr. President, this is a simple amendment and it is noncontroversial. I urge its adoption.

Mr. STEVENS. I ask for adoption of the committee substitute as amended by the Simpson-Cranston amendment.

The PRESIDING OFFICER. The question is on agreeing to the committee amendment as amended.

The committee amendment, as amended, was agreed to.

The PRESIDING OFFICER. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed for a third reading and was read the third time.

Mr. STEVENS. Mr. President, I now ask the Chair to lay before the Senate Calendar No. 1106, which is H.R. 5168, the House companion bill.

The PRESIDING OFFICER. Without objection, it is so ordered. The bill will be stated by title.

The assistant legislative clerk read as follows:

A bill (H.R. 5168) to amend title 38, United States Code, to revise and improve Veterans' Administration health programs, and for other purposes.

Mr. STEVENS. Mr. President, I move to strike all after the enacting clause of H.R. 5168 and insert in lieu thereof the provisions of S. 2514, as the Senate has just amended it.

The motion was agreed to.

The PRESIDING OFFICER. The bill is open to further amendment. If there be no further amendment to be proposed, the question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed for a third reading, was read the third time, and passed, as follows:

S. 3514

Resolved, That the bill from the House of Representatives (H.R. 5618) entitled "An Act to amend title 38, United States Code, to revise and improve Veterans' Administration health programs, and for other purposes", do pass with the following amendments: Strike out all after the enacting clause and insert:

That (a) this Act may be cited as the "Veterans' Administration Health Care Amendments of 1984".

(b) Except as otherwise specifically provided whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

COORDINATION OF VETERANS' ADMINISTRATION-COMMUNITY REFERRAL ASSISTANCE AND SERVICES

SEC. 2. (a) Chapter 73 is amended by adding at the end of subchapter 1 the following new section:

"§ 4120. Coordination of referral assistance and services

"In order to improve the provision, and enhance the management, of health-care and health-related services by the Veterans' Administration and other sources to veterans who are eligible for care under chapter 17 of this title, with a special emphasis on veterans who are 65 years of age or older, and who are determined by the Administrator to be in need of assistance under this section, the Administrator shall designate one organizational unit in each Veterans' Administration health-care facility for the purpose of coordinating the provision of referral assistance, and facilitating and helping to coordinate the provision of such services not at Veterans' Administration expense, to such eligible veterans when such referral is reasonably necessary for the health of such veterans. The Administrator shall carry out this section (1) in a manner consistent (A) with the policy of the United States, set forth in section 409(a) of Public Law 97-306, that the Veterans' Administration shall maintain a comprehensive, nationwide health-care system for the direct provision of quality health-care services to eligible veterans, (B) with the mandate of section 4101(a) of this title that the Department of Medicine and Surgery shall provide a complete medical and hospital service for the medical care and treatment of veterans, and (C) with the United States Government's historic, firm commitment, and moral obligation, as embodied in this title, to provide care for veterans with service-connected disabilities, and (2) in conjunction with local, State, Federal, and private agencies providing and coordinating the provision of services to elderly persons and with other pertinent public and private agencies.".

(b) The table of sections at the beginning of chapter 73 is amended by adding after the item relating to section 4119 the following:

"4120. Coordination of referral assistance and services.".

ALCOHOL AND DRUG TREATMENT AND REHABILITATION

SEC. 3. (a) Section 620A is amended—

(1) by striking out "pilot" in subsection (a)(1) both places it appears;

(2) by striking out "fifth" and inserting in lieu thereof "seventh" and by striking out "pilot" in subsection (e);

(3) in subsection (f)—

(A) by inserting "(1)" before "Not"; and

(B) by inserting before the period "prior to the amendment of this section by the Veterans' Administration Health Care Amendments of 1984"; and

(C) by adding at the end the following new paragraph:

"(2) Not later than March 1, 1986, and March 1, 1987, the Administrator shall report to such committees on the findings and recommendations of the Administrator pertaining to the operation of the program authorized by subsection (a) during the preceding fiscal year and shall include in such report information for such year regarding average duration of participation of veterans, rates of successful rehabilitation, and any changes in average and maximum allowable charges per veteran under contracts entered into by the Veterans' Administration as part of such program."; and

(4) by adding at the end the following new subsection:

"(h) Not later than 12 months after the date of the enactment of this subsection, the Administrator shall prescribe regulations to provide guidelines for the treatment and rehabilitation of veterans for alcohol or drug dependence or abuse disabilities under this chapter in facilities over which the Administrator has direct jurisdiction. Such guidelines shall include guidance—

"(1) on the duration of such treatment and rehabilitation under this chapter, taking into account the duration of such treatment and rehabilitation in non-Veterans' Administration programs and identifying specifically duration in detoxification, inpatient-acute care, inpatient-rehabilitation and inpatient-extended care, outpatient care, and followup services; and

"(2) on the provision of referral assistance and the development, implementation, and monitoring of individual treatment plans and followup for veterans receiving such care and treatment.".

(b) Not late than March 1, 1985, and March 1 of each subsequent year, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report containing a comprehensive survey of the activities during the preceding fiscal year of all Veterans' Administration-operated programs providing treatment and rehabilitation for alcohol or drug dependence or abuse disabilities, identifying, by facility, the number of beds involved, the number of patients and episodes of care (whether inpatient-acute, inpatient-rehabilitation, inpatient-extended, or outpatient), the specific treatment methodologies employed, average lengths of participation, rates of successful rehabilitation, and staffing levels and standards, together with a national summary of such information. The third such report shall also contain information on the effectiveness of such treatment and rehabailitation in light of the regulations prescribed under subsection (h) of section 620A (as added by the amendment made by subsection (a)(4) of this section), including information on diagnostic methodologies employed, use of case-management approaches and discharge planning, lengths of participation, treatment results, methods used for approving, evaluating, and monitoring the use of non-Veterans' Administration facilities under section 620A, and referral and followup activities for veterans discharged from such programs and such facilities.

(c) The section heading of section 620A and the item relating to such section in the table of sections at the beginning of chapter 17 are each amended by striking out the semicolon and "pilot program".

MEDICAL AND REHABILITATIVE DEVICES

Sec. 4. Section 617 is amended—

(1) by redesignating such section as subsection (a); and

(2) by adding at the end the following new subsection:

"(b) In order to assist in overcoming the handicap of deafness, the Administrator may provide assistive devices, including telecaptioning television decoders, to veterans who are profoundly deaf and entitled to compensation on account of hearing impairment.".

POST-TRAUMATIC-STRESS DISORDER

Sec. 5. (a)(1) In order to enhance the Veterans' Administration's capability to diagnose and treat post-traumatic-stress disorder (hereinafter in this section referred to as "PTSD"), the Chief Medical Director of the Veterans' Administration shall establish in the Department of Medicine and Surgery a Special Committee on Post-Traumatic-Stress Disorder (hereinafter in this section referred to as the "Special Committee") and shall appoint qualified employees of the Department to serve on the Special Committee.

(2) The Special Committee shall assess, and carry out a continuing assessment of, the capacity of the Veterans' Administration to provide diagnosis and treatment to eligible veterans with PTSD and shall advise the Chief Medical Director regarding the development of policies, the provision of guidance, and the coordination of services for the diagnosis and treatment of veterans with PTSD in inpatient PTSD units, other inpatient psychiatric programs, outpatient mental health clinics, and readjustment counseling programs of the Veterans' Administration. The Special Committee shall also make recommendations to the Chief Medical Director for guidance regarding appropriate diagnostic and treatment methods and referral for and coordination of follow-up care and with respect to the evaluation of PTSD treatment programs, the conduct of research concerning such diagnosis and treatment (taking into account the provisions of subsection (b) of this section), special programs of education and training on PTSD for employees of the Department of Medicine and Surgery and the Department of Veterans' Benefits (also taking into account such provisions), the appropriate allocation of resources for all such activities, and any specific steps that should be taken to improve such diagnosis and treatment and to correct any deficiencies in the operations of inpatient PTSD units.

(b) The Chief Medical Director of the Veterans' Administration shall establish and operate a National Center on PTSD (A) to carry out and promote research into, and the training of health-care and related personnel in, the diagnosis and treatment of veterans with PTSD, and (B) to serve as a resource center for and to promote and to seek to coordinate the exchange of information regarding all research and training activities carried out by the Veterans' Administration, and by other Federal and non-Federal entities, with respect to PTSD.

(c)(1)(A) Not later than 180 days after the date of the enactment of this Act, the Administrator shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report on the implementation of subsections (a) and (b).

(B) The report required by subparagraph (A) shall contain—

(i) a list of the members of the Special Committee,

(ii) the assessment of the Chief Medical Director of the Veterans' Administration, after consultation with the Special Committee, regarding the capability of the Veterans' Administration to meet the needs of Vietnam veterans, former prisoners of war, and other eligible veterans for inpatient and outpatient PTSD diagnosis and treatment (both through PTSD inpatient treatment units and otherwise) as well as a description of the results of any evaluations that have been made of PTSD inpatient treatment units in existence on the date of the enactment of this Act,

(iii) the plans of the Special Commitee for further assessments of the capability of the Veterans' Administration to diagnose and treat veterans with PTSD,

(iv) the recommendations made by the Special Committee to the Chief Medical Director,

(v) a description of the steps taken, plans made (and a timetable for their execution), and resources to be applied to implement subsections (a) ikand (b), and

(vi) the assessment of the Administrator of the capacity of the Veterans' Administration to meet in all geographic areas of the United States the needs described in clause (ii) and any plans and timetable for increasing that capacity (including the costs of such action).

(2) Not later than February 1, 1986, and February 1 of each subsequent year, the Administrator shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report containing information updating the report or reports submitted under this subsection prior to the submission of such report.

REPORT ON VETERANS' ADMINISTRATION PROGRAMS FOR TERMINALLY ILL VETERANS

Sec. 6. (a) Not later than September 30, 1985, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report on programs of the Veterans' Administration to furnish palliative care, supportive counseling, and other medical services to terminally ill veterans and, pursuant to section 601(6)(B) of title 38, United States Code, supportive counseling to members of such veterans' families.

(b) The report required by subsection (a) shall include—

(1) a review of Veterans' Administration policies and guidelines on the provision of care, counseling, and services described in subsection (a);

(2) a review of the care, counseling, and services furnished, including the treatment modalities used and services furnished by the Veterans' Administration;

(3) an analysis and a comparison of the care, counseling, and services furnished with respect to terminally ill veterans in hospice and other Veterans' Administration programs, including a comparison of the routine and ancillary services, of the duration of inpatient and outpatient treatment and hospital-based home care, and of the cost of care furnished in such programs;

(4) an explanation of how the care, counseling, and services described in subsection (a) is or will be included in the overall plans of the Veterans' Administration for providing health care to older veterans in the future and the extent to which plans to furnish hospice care are included in such plans;

(5) a review of any steps taken to arrange for the exchange of information between Veterans' Administration facilities providing the care, counseling, and services described in subsection (a) and non-Veterans' Administration facilities providing similar care, counseling, and services; and

(6) proposals for such administrative or legislative action as the Administrator may consider appropriate in light of the information provided in the report.

AUTOMOBILE ADAPTIVE EQUIPMENT

Sec. 7. (a) Subsection (c) of section 1903 is amended to read as follows:

"(c)(1) An eligible person shall not be entitled to adaptive equipment under this chapter for more than two automobiles or other conveyances (A) at any one time, or (B) except as provided in paragraph (2) of this subsection, in any four-year period.

"(2) If, in a case in which the limitation set forth in paragraph (1)(B) of this subsection precludes an eligible person from being entitled to adaptive equipment, the Administrator determines that, due to circumstances beyond the control of the eligible person, one of the automobiles or other conveyances for which adaptive equipment was provided in the applicable four-year period is no longer available for the use of such person, the Administrator may, as a matter of discretion and pursuant to regulations which the Administrator shall prescribe, provide adaptive equipment for such person for an additional automobile or other conveyance during such period.".

(b)(1) Except as provided in paragraph (2), the amendment made by subsection (a) shall take effect on October 1, 1984.

(2) In the case of a person who was provided adaptive equipment under chapter 39 of title 38, United States Code, for an automobile or other conveyance after September 30, 1980, but prior to October 1, 1984, and who has available for use such automobile or other conveyance on the date of the enactment of this Act, the first four-year period applicable to such person under subsection (c) of section 1903 of such title (as amended by subsection (a)) shall begin on the most recent date prior to October 1, 1984, on which such individual was provided such equipment.

READJUSTMENT COUNSELING

Sec. 8. (a) Section 612A(g)(2)(B) is amended—

(1) by striking out "and" at the end of clause (i);

(2) by striking out the period at the end of clause (ii) and inserting in lieu thereof a semicolon and "and"; and

(3) by adding after clause (ii) the following:

"(iii) assessments of whether or not individuals who—

"(I) are veterans who served on active duty (aa) during World War II or the Korean conflict (with particular emphasis on those who engaged in combat with the enemy), (bb) during any period and who were prisoners of war, or (cc) after May 7, 1975 (with particular emphasis on those who served in areas during periods in which members of the Armed Forces in such areas were subjected to danger from armed conflict comparable to the danger to which members of the Armed Forces have been subjected in combat with the enemy during a period of war), and

"(II) members of the Armed Forces serving on active duty who (aa) served on active duty during World War II or the Korean conflict (with particular emphasis on those who engaged in combat with the enemy) or after May 7, 1975 (with particular emphasis on those who served in areas during periods described in division (I)(cc) of this clause), or (bb) were prisoners of war,

need readjustment counseling and, if so, the Administrator's recommendations on the most desirable means by which such needs should be met, taking into account the resources that would be required to meet such needs and specifically whether such persons should be made eligible for readjustment counseling under this section and, if so, what effect that eligibility would have on the availability of such services for Vietnam-era veterans.

The Administrator may submit the assessments and recommendations described in subclause (iii) at any time prior to April 1, 1987.".

(b)(1) Not later than 180 days after the date of the enactment of this Act, the Administrator of Veterans' Affairs and the Secretary of Defense shall submit to the appropriate committees of the Congress a joint report setting forth—

(A) their recommendations, taking into account the extent of the availability of Veterans' Administration resources to provide readjustment counseling to Vietnam-era veterans, on the appropriateness and desirability of extending eligibility for readjustment counseling under section 612A of title 38, United States Code, to individuals who are serving on active duty in the Armed Forces of the United States and (i) who also served on such active duty during the Vietnam era (as defined in section 101(29) of such title (as amended by section 8 of this Act)), or (ii) who also served on active duty after May 7, 1975, in an area during a period in which hostilities (as defined in paragraph (2) of this subsection) occurred in such area;

(B) their determinations as to (I) whether, if eligibility for such readjustment counseling were so extended, the Veterans' Administration and the Department of Defense would enter into an agreement or agreements pursuant to which the Department of Defense would reimburse the Veterans' Administration for such counseling provided to such individuals while serving on active duty, (II) if so, whether or not such reimbursement would be made without the necessity of the Veterans' Administration providing the Department of Defense with the names of the individuals so counseled and, if not, whether or not a requirement that such names be provided would discourage active-duty personnel from requesting such services, and (III) the manner and extent to which the Veterans' Administration and the Department of Defense would undertake to carry out outreach activities to inform such individuals about the availability of such counseling; and

(C) any other information, determinations, or recommendations pertinent to the subject matter of the report that the Administrator and Secretary consider appropriate.

"(C) policies with respect to the exercise by Veterans' Administration security service officers of the enforcement and arrest authorities granted in subsection (b) of this section.

"(D) the scope and duration of training that is required for Veterans' Administration security service officers, with particular emphasis on dealing with situations involving patients, and

"(E) rules limiting the carrying and use of weapons by Veterans' Administration security service officers.

The rules prescribed under clause (A) of this paragraph, together with the penalties for violations thereof, shall be posted conspicuously on such property.

"(2) Whoever violates any rule prescribed under paragraph (1)(A) of this subsection shall be fined not more than $500 or imprisoned not more than six months (or such lesser amount or period of time as the Administrator prescribes in the regulations prescribed under paragraph (1) of this subsection), or both.

"(b) The Administrator may designate employees of the Veterans' Administration as Veterans' Administration security service officers. Such officers shall enforce Federal laws, and the rules prescribed under subsection (a)(1)(A) of this section, on Veterans' Administration property. Any Veterans' Administration security service officers, subject to any restrictions under the regulations prescribed under subsection (a) of this section, may make an arrest, with or without a warrant, for any offense on Veterans' Administration property if (1) such offense occurs in such officer's presence, or (2) such officer has reasonable grounds to believe (A) that the offense constitutes a violation of any law of the United States or of any rule prescribed under subsection (a)(1)(A) of this section, and (B) that the person to be arrested has committed that offense.

"(c) With the agreement of the head of the agency concerned, the Administrator may use the facilities and services of Federal, State, and local law enforcement agencies when it is economical and in the public interest to do so.

"(d)(1) Notwithstanding subchapter I of chapter 59 of title 5, the Administrator, pursuant to regulations which the Administrator shall prescribe consistent with paragraph (2) of this subsection, may pay allowances for the purchase of uniforms to any Veterans' Administration security service officer who is required to wear a prescribed uniform in the performance of official duties.

"(2) Allowances that the Administrator may pay under paragraph (1) of this subsection shall not exceed—

"(A) at the time the individual is first employed as a Veterans' Administration security service officer, $400; and

"(B) at the beginning of the first fiscal year that begins after the individual has completed 12 months of service as a Veterans' Administration security service officer and at the beginning of each subsequent fiscal year, $200.".

(b)(1) The provisions of section 218 of title 38, United States Code, other than clause (2) of subsection (a) of such section, as in effect on the day before the date of the enactment of this Act shall remain in effect until the date on which the Administrator of Veterans' Affairs prescribes the regulations required to be prescribed by subsection (a) of such section as amended by subsection (a) of this section.

(2) The authority of the Administrator to designate officers and employees of the Veterans' Administration to act as special policemen under section 218(a)(2) of such title as in effect on the day before the date of the enactment of this Act shall remain in effect until the date on which the Administrator first exercises the authority under subsection (b) of section 218 of such title as amended by subsection (a) of this section.

(c) The item relating to such section in the table of sections at the beginning of chapter 3 of such title is amended to read as follows:

"218. Security and law enforcement on property under the jurisdiction of the Veterans' Administration.".

(d) Section 4107(g) is amended—

(1) in paragraph (1)—

(A) by striking out "or" in clause (A);

(B) by striking out the comma and inserting in lieu thereof a semicolon and "or" in subclause (iv) of clause (B); and

(C) by inserting after clause (B) the following new clause:

"(C) of employees providing security services, pursuant to section 218 of this title, in buildings under the jurisdiction of the Administrator (and not under the control of the Administrator of General Services) that are used for the purpose of providing health care,";

(2) by striking out "health-care" each place it appears in paragraphs (2)(A) and (4); and

(3) by inserting "or (C)" after "(B)" in paragraph (4).

COMPTROLLER GENERAL REPORT ON MEDICAL PERSONNEL STAFFING LEVELS

Sec. 10. Section 5010(a)(4)(C) is amended to read as follows:

"(C) Not later than fifteen days after the expiration of the period for the submission of a certification by the Director of the Office of Management and Budget under subparagraph (B) of this paragraph, the Comptroller General shall submit to the appropriate committees of the Congress a report stating the Comptroller General's opinion as to whether the Director has complied with the requirements of such subparagraph in providing such certification and in providing to the Veterans' Administration such funded personnel ceiling.".

REPORT ON FEDERAL GOVERNMENT RESPONSIBILITY TO INDIVIDUALS WHO SERVED WITH VOLUNTARY CIVILIAN ORGANIZATIONS IN VIETNAM

Sec. 11. (a)(1) The purpose of this section is to provide a basis for the executive branch and the Congress to evaluate the question of United States Government responsibility, and alternative approaches, for providing individuals who served for a period of at least thirty days in the Republic of Vietnam during the Vietnam era as employees of voluntary organizations, determined by the Administrator of Veterans' Affairs, in consultation with the Secretary of Defense, to be organizations which provided significant assistance to the United States Armed Forces in the Republic of Vietnam during the Vietnam era, with Federal and other benefits and services (including, but not limited to, health care and monetary compensation for disabilities which may be related to exposure to dioxin or be the result of traumatic events), either through the Veterans' Administration or otherwise, and for assisting such individuals in connection with disabilities they may have incurred as a result of such service.

(2) In order to carry out the purpose stated in paragraph (1), the Administrator, the Secretary of Defense, and the Secretary of Health and Human Services, not later than 180 days after the date of the enactment of this Act, shall submit to the appropriate committees of the Congress a joint report on the question of United States Government responsibility and setting forth various alternative approaches (together with comments on the appropriateness and the advantages and disadvantages of each) and any recommendations by such officials for legislative and administrative action with respect thereto, for establishing a program for providing such benefits, services, and assistance to such individuals.

(b) For the purpose of this section, the terms "Armed Forces" and "Vietnam era" have the meanings given such terms in section 101 (10) and (29), respectively, of title 38, United States Code.

CONTRACT CARE IN PUERTO RICO AND THE VIRGIN ISLANDS

Sec. 12. Section 601(4)(C)(v) is amended by striking out "September 30, 1984," and inserting in lieu thereof "September 30, 1985,".

HEALTH CARE IN REMOTE AREAS

Sec. 13. (a) The Congress finds that—

(1) many veterans with service-connected disabilities and other veterans eligible for certain health-care services from the Veterans' Administration, within the limits of Veterans' Administration facilities, reside in

areas of the United States that are geographically remote from health-care facilities over which the Administrator of Veterans' Affairs has direct jurisdiction;

(2) for many such veterans such health-care facilities are geographically inaccessible and for many other such veterans the inconvenience of travel to such facilities discourages them from seeking health-care services from the Veterans' Administration; and

(3) a study conducted by the Administrator of eligible veterans residing in remote areas and these veterans' utilization of Veterans' Administration health-care services would provide useful information on the feasibility and appropriateness of alternative approaches to furnishing health-care services to such veterans.

(b)(1) The Administrator shall carry out a study to develop information about veterans who reside in remote areas and are eligible for health-care services from the Veterans' Administration and to develop alternative approaches that could be adopted to furnish such veterans with such services. In carrying out the study, the Administrator shall—

(A) develop, to the maximum feasible extent, statistics on the number of eligible veterans who, during fiscal year 1985—

(i) reside less than 50 miles from the nearest Veterans' Administration medical facility,

(ii) reside between 50 miles and 100 miles from the nearest Veterans' Administration medical facility,

(iii) reside between 100 miles and 200 miles from the nearest Veterans' medical facility, or

(iv) reside more than 200 miles from the nearest Veterans' Administration medical facility;

(B) develop, by each group of residences described in clause (A), statistics on the numbers of eligible veterans who, during such year—

(i) utilize Veterans' Administration medical facilities,

(ii) receive inpatient care in such facilities (including the typical lengths of stay of such veterans in such facilities),

(iii) receive outpatient care from such facilities, or

(iv) receive followup health-care services from such facilities;

(C) develop such further statistics and gather such additional information as the Administrator considers appropriate to carry out the study; and

(D) develop breakdowns of the statistics described in clauses (A) and (B) with respect to age, service connection, and financial need regarding the applicable veteran populations.

(2) Not later than January 1, 1986, the Administrator shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a full report on such study. Such report shall include—

(A) the statistics and breakdown developed and information gathered pursuant to paragraph (1);

(B) the Administrator's findings on the extent of the need for the Veterans' Administration to increase health-care services in remote areas; and

(C) the Administrator's findings and recommendations regarding the advantages and disadvantages of the Veterans' Administration contracting for and making other arrangements for the furnishing of health-care services to eligible veterans in remote areas.

(3) Not later than July 1, 1986, the Administrator shall submit to such committees a report describing an experimental program that could feasibly be carried out through projects in five remote areas, selected on the basis of the statistics, breakdowns, information, and findings included in the report submitted under paragraph (2), to demonstrate alternative approaches for the Veterans' Administration to furnish health-care services to eligible veterans in remote areas. The report shall also include a description of the health-care services, and a detailed breakdown of the costs for them, that could be furnished under such an experimental program to such veterans in each such area, along with the recommendations (and the reasons therefor) of the Administrator regarding whether any such projects should be carried out and such recommendations for legislative or administrative action as the Administrator considers appropriate in light of the information contained in the report.

USE OF CERTAIN LANDS BY THE UNIVERSITY OF CALIFORNIA

SEC. 14. (a) Notwithstanding the Act described in subsection (b), the Administrator of Veterans' affairs shall execute such legal documents as are necessary to permit the of the real property described in subsection (b) (or any portion of such property) for educational or cultural purposes in addition to the use of such property as a research and medical center and for allied purposes. The Administrator may carry out the preceding sentence subject to such terms and conditions as the Administrator determines are necessary in order to protect the interests of the United States.

(b) The real property referred to in subsection (a) is the property transferred to the State of California for the use of the University of California by a quitclaim deed dated December 10, 1948, executed by the Administrator of Veterans' Affairs under the Act entitled "An Act to authorize the Administrator of Veterans' Affairs to transfer a portion of the Veterans' Administration center at Los Angeles, California, to the State of California for the use of the University of California", approved June 19, 1948 (62 Stat. 559), and recorded in the land records of the County of Los Angeles, California, at page 307 of book 29032.

(c) Any document executed to carry out subsection (a) shall provide that the property involved shall revert to the United States if it ceases to be used as a research and medical center or for educational or cultural purposes.

ACQUISITION OF BUILDINGS FOR STATE HOME FACILITIES

SEC. 15. Subchapter III of chapter 81 is amended as follows:

(1) Section 5031(c) is amended—

(A) by striking out "term 'construction' means" and inserting "terms 'constructed' and 'construction' refer to"; and

(B) by inserting "the acquisition of existing buildings for use as domiciliary or nursing home care facilities," after "home buildings,";

(2) Section 5032 is amended by inserting "to acquire existing buildings for use as State home facilities for furnishing such care to veterans," after "nursing home care to veterans,"; and

(3) Section 5035(a) is amended—

(A) by striking out "and" at the end of clause (7); and

(B) in clause (8),

(I) by striking out "sections 276a through 276a-5 of title 40" and inserting in lieu thereof "the Act of March 3, 1931 (40 U.S.C. 276a-276a-5)"; and

(II) by striking out the period at the end and inserting in lieu thereof a comma and "and"; and

(C) by inserting at the end the following new clause:

"(9) in the case of a project of acquisition of a facility, reasonable assurance that the estimated total costs of acquisition of the facility and of any expansion, remodeling, and alteration of the acquired facility necessary to meet Veterans' Administration standards shall not be greater than the estimated cost of constructing an equivalent new facility.".

SENSE OF THE CONGRESS REGARDING CERTAIN GRACE COMMISSION RECOMMENDATIONS

SEC. 16. (a) The Congress makes the following findings:

(1) The Department of Medicine and Surgery of the Veterans' Administration, established by an Act of the Congress, represents a national commitment by the Government to meet the medical needs of eligible veterans, especially those who have been disabled as a result of their military service.

(2)(A) Section 409(a) of Public Law 97-306 states that it is the policy of the United States that the Veterans' Administration "shall maintain a comprehensive, nationwide health-care system for the direct provision of quality health-care services to eligible veterans".

(B) Section 5010(a)(1) of title 38, United States Code, requires the Veterans' Administration to operate and maintain a total of not less than 90,000 hospital and nursing home beds and such additional beds as may be necessary for the Veterans' Administration to meet its contingency obligations to assist the Department of Defense in times of war or national emergency in caring for the casualties of such war or national emergency.

(3) The President's Private Sector Survey on Cost Control (commonly known as and hereinafter referred to as the "Grace Commission") has recommended that Veterans' Administration hospitals reduce the average length of stay of their inpatients to a level comparable to that found in the private sector; however, many Veterans' Administration hospital patients have severe and multiple disabilities requiring extensive treatment.

(4) The Grace Commission has recommended that funds for construction of Veterans' Administration hospitals not already under contract be deleted from the Veterans' Administration budget, that bids be invited from private hospital management companies to lease hospital facilities to the Veterans' Administration under long-term contracts, and that such facilities be managed by private companies under short-term performance contracts.

(5) The Grace Commission has recommended that nursing home construction by the Veterans' Administration be entirely discontinued and that the Veterans' Administration contract for the operation of nursing home care facilities by the private sector.

(6) The Grace Commission has recommended that the Veterans' Administration eliminate such number of Veterans' Administration acute care hospital beds as is necessary to achieve an 80 percent occupany rate for such beds.

(7) The Grace Commission has recommended that the Veterans' Administration consider converting some underutilized acute health-care facilities to extended health-care facilities and phasing out old hospital facilities which may be in need of replacement or significant reconstruction; however, demographic information compiled by the Veterans' Administration shows a forthcoming major increased demand on the Veterans' Administration from the aging veterans of World War II for acute as well as long-term health care.

(8) A joint study of the Grace Commission's recommendations conducted by the Congressional Budget Office and the General Accounting Office and submitted to Congress in February, 1984, concluded that the potential deficit reductions that might result in 1985 through 1987 from implementation of the Grace Commission's recommendations would be much smaller than the three-year savings projected by the Commission.

(9) The Congress desires to reassure veterans that the Congress remains firmly committed to an independent and comprehensive, nationwide health-care system within the Veterans' Administration, capable of providing quality care to eligible veterans.

(b) In light of the findings made in subsection (a), it is the sense of the Congress (1) that the aforementioned recommendations of the President's Private Sector Survey on Cost Control relating to the Veterans' Administration health-care system must be evaluated in light of the national policies described in subsection (a)(2) and in light of the aforementioned factors, and (2) that no action to implement such recommendations should be taken without their policy implications having first been given full and careful consideration, after appropriate hearings, by the Committees on Veterans' Affairs of the House of Representatives and the Senate.

AUTHORITY TO ADJUST RATES OF PAY FOR CERTAIN PSYCHOLOGISTS

Sec. 17. Section 4104 is amended—

(1) by inserting "(other than those described in paragraph (3))" after "psychologists" in paragraph (2); and

(2) by striking out "Certified" in paragraph (3) and inserting in lieu thereof "Clinical or counseling psychologists who hold diplomas as diplomates in psychology from an accrediting authority approved by the Administrator, certified".

PROGRAM GUIDE ON ALZHEIMER'S DISEASE

Sec. 18. Not later than 180 days after the date of the enactment of this Act, the Administrator shall disseminate to appropriate Veterans' Administration medical facilities and submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a program guide to clarify Veterans' Administration policy regarding the authorization and provision of treatment, including diagnosis, information, outpatient services, hospital care, and nursing home care, of veterans who are eligible for services under title 38, United States Code, and who are suffering from Alzheimer's disease and related neurological diseases.

NAMING OF VETERANS' ADMINISTRATION MEDICAL CENTERS

Sec. 19. (a) The Veterans' Administration Medical Center in Murfreesboro, Tennessee, shall after the date of the enactment of this Act be known and designated as the "Sergeant Alvin C. York Veterans' Administration Medical Center". Any reference to such medical center in any law, regulation, map, document, record, or other paper of the United States shall after such date be deemed to be a reference to the Sergeant Alvin C. York Veterans' Administration Medical Center.

(b) The Veterans Administration Medical Center in Milwaukee, Wisconsin, shall after the date of the enactment of this Act be known and designated as the "Clement J. Zablocki Veterans' Administration Medical Center". Any reference to such medical center in any law, regulation, map, document, record, or other paper of the United States shall after such date be deemed to be a reference to the Clement J. Zablocki Veterans' Administration Medical Center.

Amend the title so as to read: "An Act to amend title 38, United States Code, to require the Veterans' Administration to develop guidance for the provision of care to veterans suffering from alcohol or drug dependence, to require the Administrator to establish a Special Committee and a National Center for Post-Traumatic-Stress Disorder, and to improve the Veterans' Administration's ability to protect persons and property on its premises; and for other purposes.".

Mr. STEVENS. Mr. President, I move to reconsider the vote by which the bill was passed.

Mr. BYRD. I move to lay that motion on the table,

The motion to lay on the table was agreed to.

Mr. STEVENS. Mr. President, on behalf of the chairman of the committee, Mr. SIMPSON, I send to the desk an amendment to the title and ask for its immediate consideration.

The PRESIDING OFFICER. The amendment will be stated.

The assistant legislative clerk read as follows:

Amend the title so as to read: "A bill to amend title 38, United States Code, to require the Veterans' Administration to develop guidance for the provision of care to veterans suffering from alcohol or drug dependence, to require the Administrator to establish a Special Committee and a National Center for Post-Traumatic-Stress Disorder, and to improve the Veterans' Administration's ability to protect persons and property on its premises; and for other purposes.".

The amendment was agreed to.

Mr. STEVENS. Mr. President, I move to reconsider the vote by which the amendment was agreed to.

Mr. BYRD. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. STEVENS. Mr. President, I move that the Senate indefinitely postpone calendar No. 929, which is S. 1514.

The PRESIDING OFFICER. Without objection, it is so ordered.

APPENDIX D

[From the Congressional Record, Vol. 130, No. 129--Part II, pp. S12892-S12906--Senate, October 3, 1984]

VETERANS HEALTH CARE ACT

Mr. BAKER. Mr. President, I ask that the Chair lay before the Senate a message from the House of Representatives on H.R. 5618.

The **PRESIDING OFFICER** laid before the Senate the following message from the House of Representatives:

Resolved, That the House agree to the amendments of the Senate to the bill (H.R. 5618) entitled "An Act to amend title 38, United States Code, to revise and improve Veterans' Administration health programs, and for other purposes", with the following amendments:

In lieu of the matter inserted by said amendment to the text of the bill, insert:

SHORT TITLE; REFERENCES TO TITLE 38, UNITED STATES CODE

SECTION 1. (a) This Act may be cited as the "Veterans' Health Care Act of 1984".

(b) Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

TITLE I—HEALTH PROGRAMS

SECURITY AND LAW ENFORCEMENT AT VETERANS' ADMINISTRATION FACILITIES

SEC. 101. (a)(1) Section 218 is amended to read as follows:

"§ 218. Security and law enforcement on property under the jurisdiction of the Veterans' Administration

"(a)(1) The Administrator shall prescribe regulations to provide for the maintenance of law and order and the protection of persons and property on land and in buildings under the jurisdiction of the Veterans' Administration and not under the control of the Administrator of General Services (hereinafter in this section referred to as 'Veterans' Administration property').

"(2) Such regulations shall include—

"(A) rules for conduct on Veterans' Administration property; and

"(B) the penalties, within the limits specified in paragraph (3) of this subsection, for violations of such rules.

"(3) Whoever violates any rule prescribed under paragraph (2)(A) of this subsection shall be fined not more than $500 or imprisoned not more than six months (or such lesser amount or period of time as the Administrator prescribes in the regulations prescribed under this subsection), or both.

"(4) The rules prescribed under clause (A) of paragraph (2) of this subsection, together with the penalties for violations of such rules, shall be posted conspicuously on property to which they apply.

"(5) The Administrator shall consult with the Attorney General before prescribing regualations under this subsection.

"(b)(1) Veterans' Administration employees who are Veterans' Administration police officers shall enforce Federal laws and the rules prescribed under subsection (a)(2)(A) of this section on Veterans' Administration property. Subject to regulations prescribed under paragraph (2) of this subsection a Veterans' Administration police officer may make arrests on Veterans' Administration property for a violation of any Federal law or of any such rule.

"(2) The Administrator shall prescribe regulations with respect to Veterans' Administration police officers. Such regulation shall include—

"(A) policies with respect to the exercise by Veterans' Administration police officers of the enforcement and arrest authorities provided by paragraph (1) of this subsection;

"(B) the scope and duration of training that is required for Veterans' Administration police officers, with particular emphasis on dealing with situations involving patients; and

"(C) rules limiting the carrying and use of weapons by Veterans' Administration police officers.

"(3) The Administrator shall consult with the Attorney General before prescribing regulations under clause (A) of paragraph (2) of this subsection.

"(4) Rates of basic pay for Veterans' Administration police officers may be increased by the Administrator under section 4107(g) of this title.

"(c)(1) The Administrator may pay an allowance under this subsection for the purchase of uniforms to any Veteran's Administration police officer who is required to wear a perscribed uniform in the performance of offical duties.

"(2) The amount of the allowance that the Administrator may pay under this subsection—

"(A) may be based on estimated average costs or actual costs;

"(B) may vary by geographic regions; and

"(C) except as provided in paragraph (3) of this paragraph, may not exceed $200 in a fiscal year for any police officer.

"(3)(A) The amount of an allowance under this subsection may be increased to an amount up to $400 for not more than one fiscal year in the case of any Veterans' Administration police officer. In the case of a person who is appointed as a Veterans' Administration police officer on or after the date on which the Administrator initially exercises the authority granted by this paragraph, an allowance in an amount established under this paragraph shall be paid at the beginning of such person's employment as such an officer. In the case of any other Veterans' Administration police officer, an allowance in an amount established under this paragraph shall be paid upon the request of the officer.

"(B) A police officer who resigns as a police officer less than one year after receiving an allowance in an amount established under this paragraph shall repay to the Veterans' Administration a pro rata share of the amount paid, based on the number of months the officer was actually employed as such an officer during the 12-month period following the date on which such officer began such employment or the date on which the officer submitted a request for such allowance, as the case may be.

"(4) An allowance may not be paid to a Veterans' Administration police officer under this subsection and under section 5901 of title 5 for the same fiscal year.

"(d) The Administrator shall furnish Veterans' Administration police officers with such weapons and related equipment as the Administrator determines to be necessary and appropriate.

"(e) With the permission of the head of the agency concerned, the Administrator may use the facilities and services of Federal, State, and local law enforcement agencies when it is economically and in the public interest to do so.".

(2) The provisions of section 218 of title 38, United States Code, other than clause (2) of subsection (a) of such section, as in effect on the day before the date of the enactment of this Act shall remain in effect until the date on which the Administrator of Veterans' Affairs prescribes the regulations required to be prescribed by subsections (a) and (b) of such section as amended by subsection (a) of this section.

(3) The item relating to such section in the table of sections at the beginning of chapter 3 of such title is amended to read as follows:

"218. Security and law enforcement on property under the jurisdiction of the Veterans' Administration.".

(b) Section 4107(g) is amended—

(1) in paragraph (1)—

(A) by striking out "or" at the end of clause (A);

(B) by striking out the comma and inserting in lieu thereof a semicolon and "or" at the end of subclause (iv) of clause (B); and

(C) by inserting after clause (B) the following new clause:

"(C) of employees who are Veterans' Administration police officers providing services under section 218 of this title,";

(2) by striking out "health-care" each place it appears in paragraphs (3)(A) and (4); and

(3) by inserting "or (C)" after "(B)" in paragraph (4).

(c) Not later than 180 days after the date of the enactment of this Act, the Administration of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the implementation of the amendments made by this section. The report shall include (1) the regulations prescribed under section 218 of title 38, United States Code, as amended by subsection (a), and (2) a description of the methodology to be used to determine how the authority provided in the amendments made by subsection (b) is to be exercised.

COMPTROLLER GENERAL REPORT ON MEDICAL PERSONNEL STAFFING LEVELS

SEC. 102. Section 5010(a)(4)(C) is amended to read as follows:

"(C) Whenever the Director of the Office of Management and Budget is required to submit a certification under subparagraph (B) of this paragraph, the Comptroller General shall submit to the appropriate committees of the Congress a report stating the Comptroller General's opinion as to whether the Director has complied with the requirements of that subparagraph. The Comptroller General shall submit the report not later than 15 days after the end of the period specified in such subparagraph for the Director to submit the certification.".

CONTRACT HEALTH CARE IN PUERTO RICO AND THE VIRGIN ISLANDS

SEC. 103. (a) Section 601(4)(C)(v) is amended by striking out "September 30, 1984" and inserting in lieu thereof "September 30, 1985".

(b) Any action by the Administrator of Veterans' Affairs in entering into a contract applicable to the period beginning on October 1, 1984, and ending on the date of the enactment of this Act for the provision of care described in subclause (v) of section 601(4)(C) of title 38, United States Code, and any waiver described in that subclause made by the Administrator that is applicable to that period, is hereby ratified with respect to that period.

EXTENSION OF AUTHORIZATION OF APPROPRIATIONS FOR GERIATRIC RESEARCH, EDUCATION, AND CLINCIAL ACTIVITIES

SEC. 104. Section 4101(f)(3) is amended by striking out the first sentence and inserting in lieu thereof the following: "There are authorized to be appropriated such sums as may be necessary for the support of the research and education activities of the centers established pursuant to paragraph (1) of this subsection.".

[illegible]

matter and the views of the Chief Medical Director on such recommendations.

(F) A summary of the results of research conducted by the Veterans' Administration relating to PTSD.

(G) A description of the steps taken, plans made (and a timetable for their execution), and resources to be applied to implement subsections (b) and (c).

(H) The assessment of the Administrator of the capacity of the Veterans' Administration to meet in all geographic areas of the United States the needs described in subparagraph (C) and any plans and timetable for increasing that capacity (including the costs of such action).

(2) Not later than February 1, 1985, and February 1 of each of the three following years, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report containing information updating the reports submitted under this subsection before the submission of such report.

ALCOHOL AND DRUG TREATMENT AND REHABILITATION GUIDELINES

SEC. 111. Not later than 6 months after the date of the enactment of this Act, the Administrator of Veterans' Affairs (1) shall issue guidelines for the treatment and rehabilitation of veterans for alcohol or drug dependence or abuse disabilities under chapter 17 of title 38, United States Code, in facilities over which the Administrator has direct jurisdiction, and (2) shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report (including a copy of such guidelines) on the implementation of this section.

TITLE II—REPORTS

REPORT ON VETERANS' ADMINISTRATION PROGRAMS FOR TERMINALLY ILL VETERANS

SEC. 201. (a) Not later than September 30, 1985, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on programs of the Veterans' Administration to furnish palliative care, supportive counseling, and other medical services to terminally ill veterans and, pursuant to section 601(6)(B) of title 38, United States Code, supportive counseling to members of such veterans' families.

(b) The report required by subsection (a) shall include the following:

(1) A review of Veterans' Administration policies and guidelines on the provision of care, counseling, and services described in subsection (a).

(2) A review of the care, counseling, and services furnished, including the treatment modalities used and services furnished by the Veterans' Administration.

(3) An analysis and a comparison of the care, counseling, and services furnished with respect to terminally ill veterans in hospice and other Veterans' Administration programs, including a comparison of the routine and ancillary services, of the duration of inpatient and outpatient treatment and hospital-based home care, and of the cost of care furnished in such programs.

(4) An explanation of how the care, counseling, and services described in subsection (a) are or will be included in the overall plans of the Veterans' Administration for providing health care to older veterans in the future and the extent to which plans to furnish hospice care are included in such plans.

(5) A review of any steps taken to arrange for the exchange of information between Veterans' Administration facilities providing the care, counseling, and services described in subsection (a) and non-Veterans' Administration facilities providing similar care, counseling, and services.

VETERANS RESIDING IN REMOTE GEOGRAPHIC AREAS

SEC. 202. (a) The Congress makes the following findings:

(1) Many veterans with service-connected disabilities and other veterans eligible for certain health-care services from the Veterans' Administration, within the limits of Veterans' Administration facilities, reside in areas of the United States that are geographically remote from health-care facilities over which the Administrator of Veterans' Affairs has direct jurisdiction.

(2) For many such veterans such health-care facilities are geographically inaccessible and for many other such veterans the inconvenience of travel to such facilities discourages them from seeking health-care services from the Veterans' Administration.

(3) A study conducted by the Administrator of eligible veterans residing in remote areas and the use by those veterans of Veterans' Administration health-care services would provide useful information on the feasibility and appropriateness of alternative approaches to furnishing health-care services to such veterans.

(b)(1) The Administrator shall carry out a study to develop information about veterans who reside in remote areas and are eligible for health-care services from the Veterans' Administration and to develop alternative approaches that could be adopted to furnish such veterans with such services. In carrying out the study, the Administrator shall develop the following information:

(A) To the maximum extent feasible, statistics on the number of eligible veterans who, during fiscal year 1985—

(i) reside less than 50 miles from the nearest Veterans' Administration medical facility,

(ii) reside between 50 miles and 100 miles from the nearest Veterans' Administration medical facility,

(iii) reside between 100 miles and 200 miles from the nearest Veterans' Administration medical facility, and

(iv) reside more than 200 miles from the nearest Veterans' Administration medical facility.

(B) Statistics, shown by each group of veterans described in clause (A), on the numbers of eligible veterans who, during fiscal year 1985—

(i) use Veterans' Administration medical facilities,

(ii) receive inpatient care in such facilities (including the typical lengths of stay of such veterans in such facilities),

(iii) receive outpatient care from such facilities, and

(iv) receive followup health-care services from such facilities.

(C) Such additional statistics and such additional information as the Administrator considers appropriate.

(D) Breakdowns of the statistics described in clauses (A) and (B) with respect to age, service connection, and financial need regarding the applicable veteran populations.

(2) Not later than January 1, 1986, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a full report on the study under paragraph (1). The report shall include—

(A) the statistics and breakdowns developed and information gathered under that paragraph;

(B) the Administrator's findings on the extent of the need for the Veterans' Administration to increase health-care services in remote areas; and

(C) the Administrator's findings and recommendations regarding the advantages and disadvantages of the Veterans' Administration contracting for and making other arrangements for the furnishing of health-care services to eligible veterans in remote areas.

(3) Not later than July 1, 1986, the Administrator shall submit to such committees a report describing an experimental program that could feasibly be carried out through projects in five remote areas, selected on the basis of the information and findings included in the report under paragraph (2), to demonstrate alternative approaches for the Veterans' Administration to furnish health-care services to eligible veterans in remote areas. The report shall include a description of the health-care services, and a detailed breakdown of the costs for them, that could be furnished under such an experimental program to such veterans in each such area, along with the recommendations (and the reasons therefor) of the Administrator regarding whether any such project should be carried out and such recommendations for legislative or administrative action as the Administrator considers appropriate in light of the information contained in the report.

TITLE III—MISCELLANEOUS

MODIFICATION OF REVERSIONARY INTEREST IN CERTAIN LAND, LOS ANGELES, CALIFORNIA

SEC. 301. (a) The Administrator of Veterans' Affairs shall execute such legal documents as are necessary to permit the use of the real property described in subsection (b) (or any portion of such property) for educational or cultural purposes in addition to the use of such property as a research and medical center and for allied purposes. The Administrator may carry out the preceding sentence subject to such terms and conditions as the Administrator requires in order to protect the interests of the United States.

(b) The real property referred to in subsection (a) is the property transferred to the State of California for the use of the University of California by a quitclaim deed dated December 16, 1948, executed by the Administrator of Veterans' Affairs under the Act entitled "An Act to authorize the Administrator of Veterans' Affairs to transfer a portion of the Veterans' Administration center at Los Angeles, California, to the State of California for the use of the University of California", approved June 19, 1948 ([illegible] Stat. [illegible]), and recorded in the land records of the County of Los Angeles, California, at page [illegible] of book [illegible].

(c) Any document executed to carry out subsection (a) of this section shall provide that the property involved shall revert to the United States if it ceases to be used as a research and medical center or for educational or cultural purposes.

NAMING OF VETERANS' ADMINISTRATION MEDICAL CENTERS

SEC. 302. (a) The Veterans' Administration Medical Center in Murfreesboro, Tennessee, shall after the date of the enactment of this Act be known and designated as the "Alvin C. York Veterans' Administration Medical Center". Any reference to such medical center in any law, regulation, map, document, record, or other paper of the United States shall after such date be deemed to be a reference to the Alvin C. York Veterans' Administration Medical Center.

(b) The Veterans' Administration Medical Center in Milwaukee, Wisconsin, shall after the date of the enactment of this Act be known and designated as the "Clement J. Zablocki Veterans' Administration Medical Center". Any reference to such medical center in any law, regulation, map, document, record, or other paper of the United States shall after such date be deemed to be a reference to the Clement J. Zablocki Veterans' Administration Medical Center.

In lieu of matter inserted by the amendment of the Senate to the title of the bill, insert: "An Act to amend title 38, United States Code, to revise and improve Veterans' Administration health programs and to improve security and law enforcement at Veterans' Administration facilities; and for other purposes.".

Mr. SIMPSON. Mr. President, I express strong support of H.R. 5618, the proposed Veterans' Health Care Act of 1984, and urge my good colleagues to join with me in approving its final passage today. The provisions of the bill are intended to make improvements in providing, under the laws administered by the Veterans' Administration, certain important benefits and services to our Nation's veterans. This measure is now before the Senate as a privileged matter in lieu of a formal conference report. The compromise agreement is derived from the provisions contained in S. 2514 as passed by the Senate on August 8, 1984, and from the provisions of H.R. 5618 as passed by the House of Representatives on May 21, 1984. The agreement has been worked out in a spirit of bipartisan cooperation during thoughtful and reasonable negotiations between the Committees on Veterans' Affairs of the House of Representatives and the Senate and is a fair and workable compromise resulting from these efforts. I urge that the Senate concur in the amendment of the House and send this measure to the President for his signature.

Mr. President, I am pleased to speak in favor of this proposed legislation. The compromise agreement contains 18 provisions relating to the following issues: The recruitment and retention of VA police officers, the due date of a recurring Comptroller General report, the authority to provide health care on a contract basis for veterans in Puerto Rico and the Virgin Islands, the authorization of appropriations for the research and education activities of the VA's Geriatric Research, Education, and Clinical Centers (GRECC), the acquisition of properties for use as State veterans' homes, the coordination of VA health care services with State and local programs, the authority to provide assistive devices for certain veterans who are profoundly deaf, the authority to adjust the rates of pay for certain VA psychologists, the waiver of mandatory reductions in military retired pay for certain physicians, the diagnosis and treatment of veterans with post-traumatic-stress disorder, the treatment and rehabilitation of veterans with alcohol and drug abuse disabilities, the VA's programs for terminally ill veterans, the need for health care services for veterans residing in remote areas, the transfer of a portion of certain property for use by the University of California, and the naming of certain VA medical centers.

The legislative history of this measure is clearly documented in the statements and reports of the committees to accompany H.R. 5618 and S. 2514 and in the joint explanatory statement to accompany the compromise agreement which follows my remarks. I will, therefore, highlight certain aspects of the various provisions and note the committees' intent with respect to those provisions.

AGING VETERANS

Mr. President, I am pleased that the compromise agreement contains several provisions relating to benefits and services for elderly veterans. There were 3 million veterans over 65 in 1980; there will be 9 million such veterans by the year 2000. In August, the VA released its long-awaited planning document, "Caring for the Older Veteran," which outlines a number of strategies and options for meeting the challenge of the older veteran. One of the goals outlined in this document is "to develop and implement appropriate linkages among VA and non-VA services targeted at meeting the needs of older individuals." The compromise agreement would support this objective by including a provision derived from one I originally introduced in S. 2514, that would require the Administrator to try to coordinate first, VA benefits and services with appropriate non-VA programs and second, information about those VA benefits and services with information about appropriate non-VA benefits and services. The committees intend that the VA, in implementing this provision, place special emphasis on veterans who are 65 years of age or older.

The compromise agreement contains another provision derived from one I introduced in S. 2514, which would also require the Administrator to submit a report to the committees on VA programs to furnish palliative care—pain relief, supportive counseling, and other medical services to terminally ill veterans and supportive counseling to their families. In light of the increasing number of elderly veterans seeking care from the VA, I believe that a review of the VA's current efforts to provide various kinds and levels of care to terminally ill veterans and its plans for integrating those efforts in the overall plans for caring for the elderly veteran is both an important and timely endeavor.

A third provision in the compromise agreement, which would benefit elderly veterans, would authorize the VA to provide grant funds to a State to enable the State to acquire an existing facility for use as a State veterans' home nursing home or domiciliary. Under current law a State may use such funds only to construct new domiciliary or nursing home buildings, or for the expansion, remodeling, or alteration of existing buildings. This provision is designed to provide States receiving such funds with greater flexibility to provide nursing home or domiciliary care to eligible veterans.

The compromise agreement contains a fourth provision related to meeting the needs of elderly veterans. This provision would make permanent the authorization of appropriations to support the research and education activities of the Geriatric Research, Education, and Clinical Centers (GRECC's), a program intended to make valuable contributions to our knowledge of and ability to treat the diseases of old age. I note that the VA's Office of Program Planning and Evaluation is beginning a review of the GRECC Program and I look forward to the results of this evaluation.

VIETNAM VETERANS

Mr. President, a provision in the compromise agreement which is derived, in part, from my original legislation, S. 2514, concerns the diagnosis and treatment of Vietnam veterans who may be suffering from post-traumatic-stress disorder (PTSD). This provision would first, authorize the chief medical director to designate special programs for the treatment of PTSD; second, require the chief medical director to establish a special committee on PTSD which would assess the VA's capacity to provide diagnosis and treatment for PTSD to veterans eligible for health care from the VA and advise the Chief Medical Director on policies, guidance, and coordination of services for such diagnosis and treatment; third, require the Chief Medical Director to establish and operate a National Center on PTSD to conduct research on and education and training of health care personnel in the diagnosis and treatment of veterans with PTSD; and fourth, require the Administrator to compile and publish research results on the causes, diagnosis, and treatment of PTSD and to promote the exchange of this information among health care personnel.

I believe the enactment of this provision sends a very clear message to our Vietnam veterans, to health care personnel, and to the Veterans' Administration that both Houses of Congress believe the complexities and mysteries surrounding PTSD—what it is, how it is diagnosed, and how it is treated—must receive priority attention so that we all can come to grips with this disorder and provide appropriate forms of treatment to those Vietnam veterans who may be experiencing it. The Congress is clearly withholding an endorsement to any particular method or modality of treatment, but endorses strongly unified, centralized efforts within the VA to develop better understanding of the needs of veterans with PTSD. I note that the Senate Committee, in its Budget Views and Estimates for the VA's Fiscal Year 1985 Budget, recommended that an additional 150 FTEE and $5.5 million be allocated to improve the VA's treatment for this disorder. It is my intention, as chairman of the Veterans' Affairs Committee, that these resources be targeted for clinical care, training and education of health care personnel, and research related to this disorder.

SPECIAL POPULATIONS

Mr. President, the compromise agreement also contains several provisions which are targeted to address certain specific needs of certain already eligible veteran populations who have particular health care needs or who reside in particular geographic areas. First, a provision of the agreement, derived from S. 2514 as originally introduced, would require the Administrator to issue, not later than 6 months after the date of enactment, guidelines for the treatment and rehabilitation of veterans for alcohol or drug dependence or abuse disabilities, and to submit a copy of the guidelines and a report on the implementation of this provision to the committees. This provision is intended to require the VA to coordinate and monitor its programs—some of which reflect a true commitment to provide innovative and compassionate care and treatment for veterans with these most complex and frustrating disabilities—in a systematic and comprehensive way. Other parts of the provision, as approved by the Senate Committee, have been deleted to allow the House Veterans' Affairs Committee an opportunity to hold hearings next year on the VA's alcohol and drug abuse treatment programs. Mr. President, I take this opportunity to note that the VA has not yet fulfilled a formal request that I made on April 3, 1984, for a comprehensive survey of activities, during the preceding fiscal year, of all VA alcohol or drug dependence or abuse treatment and rehabilitation programs. I believe the results of this survey would be useful to the Congress in its responsibilities to conduct oversight of the VA in this regard and to the VA in its efforts to plan for the needs of these veterans. I am most concerned that 6 months have elapsed since my request for a survey was made. In response to the concerns which I have raised about the delay, I have been informed that the survey instrument was transmitted to the appropriate VA medical facilities last week. The Director of the VA's Alcohol and Drug Abuse Treatment Programs has assured the committee's staff that the survey is projected to be completed by the end of December 1984 and that a study of the treatment outcome of 1,800 veterans who had received treatment for alcohol or drug abuse disabilities will be conducted and completed by the summer of 1985. It is my intention that the VA complete the survey and the study as soon as possible. I look forward to receiving the results.

Mr. President, the compromise agreement contains a provision which would provide the Administrator with the authority to provide devices to assist in overcoming the handicap of deafness, including telecaptioning television decoders, to certain veterans who are profoundly deaf. This provision was part of S. 2514, as originally introduced. It is intended to provide the VA with specific authority to issue rehabilitative devices to a profoundly deaf veteran with a service-connected hearing impairment. It is my desire that these devices make a worthwhile contribution to efforts made to offset any disability of the veteran that may have resulted because of the veteran's profound hearing impairment.

Mr. President, the compromise agreement would extend, for 1 year until September 30, 1985, the Administrator's authority to provide hospital care and medical services to eligible veterans who reside in Puerto Rico and the Virgin Islands. The joint explanatory statement which accompanies the compromise agreement reflects my very strong dissatisfaction with this extraordinary authority and its implementation by the VA. I would like to reiterate my views that it is imperative that the VA first, plan—in a comprehensive way—for the needs of eligible veterans in these areas, second, increase its efforts to oversee the services provided on a contract basis, third, ensure that services are provided only to those veterans who are eligible for VA services and benefits, fourth, determine the appropriateness of the kinds and levels of care provided, and fifth, initiate and implement a rigorous effort to ensure that the care provided in non-VA facilities adheres to quality assurance standards comparable to those set up by JCAH and to which all inhouse VA programs are subject. Through quality assurance efforts are a critical aspect of the VA's responsibilities to our Nation's veterans. Unless such efforts are undertaken, I would support a measure to discontinue this authority in the future.

Mr. President, there are seven additional provisions which I do support but about which I will not express any additional views. In conclusion I would wish to sincerely thank my good friend and distinguished colleague from California, Senator ALAN CRANSTON, the ranking minority member, for his invaluable cooperation throughout the entire legislative process of this measure and to each of the other committee members and colleagues for their contributions.

In addition, I should like to thank the very able members of the majority staff for their efforts—Anthony J. Principi, chief counsel and Staff Director; Julie Susman, Legislative Director; Cynthia Alpert; Victor Raymond; Kathleen McTighe; Carol DeAngelis; Becky Hucke; Kay Eckhardt, for her diligent and top-notch administrative support throughout the crafting of this legislation; Judy Sanders; and our editorial director, James MacRae; as well as members of the very capable minority staff—Jonathan Steinberg, Ed Scott, Bill Brew, Jennifer McCarthy, Ingrid Post, and Charlotte Hughes. The hard work and cooperation of my friend and most worthy counterpart on the House Veterans' Affairs Committee, G. V. "SONNY" MONTGOMERY, the steady hand of my friend, JOHN PAUL HAMMERSCHMIDT, ranking minority member, and the very able committee staff including Mack Fleming, chief counsel, Pat Ryan, Richard Fuller, and Rufus Wilson, minority counsel, were most essential to the achievement of this equitable compromise.

Mr. President, I urge my colleagues to join me in supporting this measure.

Mr. President, I submit the House/Senate explanatory statement which has been prepared in lieu of the joint statement which would accompany a formal conference report and ask unanimous consent that it appear in the RECORD at the conclusion of my remarks.

There being no objection, the statement was ordered to be printed in the RECORD, as follows:

EXPLANATORY STATEMENT OF HOUSE BILL, SENATE AMENDMENT (S. 2514), AND COMPROMISE AGREEMENT ON H.R. 5618, THE VETERANS' HEALTH CARE ACT OF 1984

This document explains the provisions of H.R. 5618 as passed by the House of Representatives, the provisions of the bill as passed by the Senate with an amendment incorporating the provisions of S. 2514 as reported, and the provisions of a compromise agreed to by the Veterans' Affairs Committees of the House and Senate. The differences between the House bill, the Senate amendment, and the compromise agreement are noted below, except for clerical corrections, conforming changes made necessary by agreements reached between the committees, and minor drafting, technical, and clarifying changes.

VETERANS' ADMINISTRATION POLICE OFFICERS

Both the House bill (section 3) and the Senate amendment (section 8) would amend present section 218 of title 38, United States Code, relating to security and law enforcement on VA property. Both the House bill and the Senate amendment contain provisions relating to the issuance by the Administrator of Veterans' Affairs of regulations concerning security and law enforcement on VA property, including rules of conduct on such property; increases in the maximum penalties for violations of such regulations (from a fine of up to $50 to a fine of up to $500 and from imprisonment for up to 30 days to imprisonment for up to 6 months); the appointment of individuals to carry out security and law enforcement activities; the authorization of such individuals to make arrests on VA property; the authorization of the Administrator to pay an allowance to such employees for the purchase of uniforms; and the authorization of the Administrator to increase the rates of basic pay for VA employees performing security and law enforcement activities (hereinafter, referred to as "VA police officers").

The House bill would restate the Administrator's authority to prescribe regulations for the maintenance of law and order and the protection of persons and property on land and in buildings under the VA's jurisdiction, including penalties for the violation of such regulations. The Senate amendment, but not the House bill, would require the Administrator to prescribe regulations with the concurrence of the Attorney General. Under the Senate amendment, the regulations would include (in addition to rules for conduct) policies concerning the exercise of enforcement and arrest authorities, scope and duration of VA police officers' training and limits on the carrying and use of weapons by such officers.

The compromise agreement contains a provision (section 101) derived from these provisions. Under the compromise agreement, the Administrator would be required, after consulting with the Attorney General, to prescribe regulations to provide for security and law enforcement on VA property, including rules for conduct on VA property and the penalties for violations of the rules of conduct. The penalties would be limited to a fine of not more than $500 or to imprisonment for not more than six months, or both. The Administrator would also be required to prescribe regulations with respect to VA police officers, including policies on enforcement and arrest authorities, the scope and duration of training, with particular emphasis on dealing with situations involving patients, and rules limiting the carrying and use of weapons. The Administrator would be required to consult with the Attorney General before prescribing the regulation on enforcement and arrest authorities.

Both the House bill and the Senate amendment contain provisions relating to VA police officers. Under the House bill, the Administrator would be authorized to appoint qualified persons to serve as VA police officers; under the Senate amendment, the Administrator would be authorized to designate VA employees as VA security service officers. Under both the House bill and the Senate amendment, such personnel would enforce Federal law and (under the House bill) the regulations or (under the Senate amendment) rules of conduct prescribed by the Administrator, and would be authorized to make arrests on VA property for violations thereof. The Senate amendment, but not the House bill, would generally restate existing standards for arrests set forth in section 218. It would specify that VA police officers would be authorized to make an arrest, with or without a warrant, for any offense on VA property if (1) the offense occurred in the officer's presence, or if (2) the officer has reasonable grounds to believe both that the offense violated a Federal law or a rule prescribed by the Administrator and that the person arrested committed the offense.

The compromise agreement contains a provision, derived from these provisions. Under the compromise agreement, personnel who are VA police officers would be required to enforce Federal laws and the rules of conduct prescribed by the Administrator and would be authorized to make arrests, subject to regulations prescribed by the Administrator, on VA property for violations of any Federal laws or such rules.

The Committees note that the compromise agreement deletes, as unnecessary in

[illegible]

facilities in Puerto Rico may be substantially below the level that is provided in the 50 States. If that is the case, the Committees believe continuation of VA authorization of such care would not be in the best interests of the health of veterans in Puerto Rico. The Committees, therefore, also direct the VA, in the strongest possible terms, to reassess the quality assurance standards used for monitoring fee-basis care provided to veterans in Puerto Rico and to improve the monitoring of such care and, as necessary, to attempt to upgrade it to an appropriate level. If such upgrading is not accomplished, the Committees believe that fee-basis contracts with facilities providing substandard care should be discontinued. In order to follow up on these concerns, the Committees plan to send a letter of inquiry to the Joint Commission on Accreditation on Hospitals in order to determine what, if any, differences exist in the accreditation standards and practices applied to Puerto Rico facilities and those in the 50 States.

EXTENSION OF AUTHORIZATION OF APPROPRIATIONS FOR GERIATRIC RESEARCH, EDUCATION, AND CLINICAL ACTIVITIES

The House bill (section 7), but not the Senate amendment, would amend section 4101(f)(3) of title 38, relating to the VA's Geriatric Research, Education, and Clinical Centers (GRECCs), to make permanent the authorization of appropriations to support the research and education activities of the GRECC program in fiscal years 1985 and beyond. Current law authorizes the appropriation of funds for fiscal years 1981 through 1984.

The compromise agreement (section 104) contains this provision.

ACQUISITION OF PROPERTIES FOR USE AS STATE VETERANS HOMES

Both the House bill (section 8) and the Senate amendment (section 15), with technical differences, would amend Subchapter III of Chapter 81 of title 38, relating to the State veterans homes remodeling-and-construction grant program, to authorize the VA to provide grant funds to a State to enable the State to acquire an existing facility for use as a State veterans' home nursing home or domiciliary facility. The use of the authority to utilize a grant for acquisition of an existing facility would be limited to situations in which reasonable assurances are provided that the cost of the purchase, together with the costs of any necessary expansion, remodeling, and alteration, would not be more costly than constructing a new facility.

The compromise agreement (section 105) follows the House provision.

COORDINATION OF VETERANS' ADMINISTRATION HEALTH CARE SERVICES WITH STATE AND LOCAL PROGRAMS

The Senate amendment (section 3), but not the House bill, would amend subchapter I of chapter 73 of title 38, relating to the general organization of the VA's Department of Medicine and Surgery, to add a new section 4120 which would require the Administrator to designate one unit in each VA health-care facility to coordinate referrals of veterans eligible for care under chapter 17 of title 38, with a special emphasis on veterans who are 65 years old or older, to non-VA entities for care not at VA expense and to help coordinate veterans' care by such entities when such referrals are reasonably necessary for the health of the veterans. The Administrator would be required to implement this new section 4120 in a manner consistent with the United States' commitment to provide a comprehensive, nationwide health-care system for direct care to eligible veterans and its obligation to provide care for service-connected disabilities.

The compromise agreement contains a provision (section 106) derived from this provision. The compromise agreement would add a new subsection (b) to present section 220 of title 38, relating to the coordination and promotion of other Federal programs affecting veterans and their dependents. The new subsection would require the Administrator to seek to achieve the effective coordination of the provision, under laws administered by the VA, of benefits and services (and information about such benefits and services) with programs conducted by State and local public and private agencies (and information about such programs). In carrying out this function, the Administrator would be required to place special emphasis on veterans who are 65 years old or older.

MEDICAL AND REHABILITATIVE DEVICES

The Senate amendment (section 4), but not the House bill, would amend section 617 of title 38, relating to invalid lifts and other devices, to provide the Administrator with the authority to provide devices to assist in overcoming the handicap of deafness, including telecaptioning television decoders, to veterans who are profoundly deaf and entitled to disability compensation on account of hearing impairment.

The compromise agreement (section 107) contains this provision.

AUTHORITY TO ADJUST RATES OF PAY FOR CERTAIN PSYCHOLOGISTS

The Senate amendment (section 17), but not the House bill, would amend present section 4104 of title 38, relating to the appointment of personnel in the VA's Department of Medicine and Surgery (DM&S), to authorize the Administrator, in order to improve the VA's ability to recruit and retain certain psychologists, to increase the minimum, intermediate, or maximum rates of basic pay for certain clinical or counseling psychologists working in DM&S. Such increases would be provided for clinical or counseling psychologists who are board certified—accredited as diplomates in psychology by an accrediting authority approved by the Administrator—if the Administrator determines, pursuant to current section 4107(g)(3), that increased rates of pay are needed to (1) provide rates of pay competitive with the rates paid to such individuals by non-Federal health-care employers in the same labor market, (2) to achieve adequate staffing at particular facilities, or (3) to recruit personnel with specialized skills.

The compromise agreement (section 108) contains this provision.

WAIVER OF MANDATORY REDUCTIONS IN MILITARY RETIRED PAY FOR CERTAIN PHYSICIANS

A related House bill (H.R. 4694 as passed by the House on June 25, 1984), but not the Senate amendment, would amend section 4107 of title 38, relating to grades and pay scales of DM&S employees, to authorize the Administrator to waive the mandatory reductions in military retirement pay of Federal employees, set forth in section 5532 of title 5, United States Code, if necessary to recruit a well-qualified doctor of medicine or osteopathy for employment in DM&S. The House bill provision would restore for DM&S the recently expired authority (delegated to the Administrator by the Director of the Office of Personnel Management) in section 5532(e) of title 5, United States Code, permitting the granting of exceptions to subsections (a), (b), and (c) of section 5532 of title 5 requiring the reduction of retired or retainer pay of retired military officers who hold a paid Government position.

The compromise agreement (section 109) contains this provision modified so as to provide the Administrator with the authority to waive such reductions in military retirement or retainer pay only when it is determined to be necessary to meet special or emergency employment needs in DM&S which result from a severe shortage of well-qualified candidates in physician positions which otherwise cannot be readily met—the standard applicable under the expired section 5532(e) of title 5.

POST-TRAUMATIC-STRESS DISORDER

Both the House bill (section 2) and the Senate amendment (section 5) contain provisions relating to the VA's provision of diagnosis and treatment for veterans with post-traumatic-stress disorder (PTSD).

The House bill, but not the Senate amendment, would amend present subchapter II of chapter 17 of title 38, relating to hospital, nursing home or domiciliary care and medical treatment, to add a new section [illegible] concerning the treatment for post-traumatic-stress disorder. Under the House bill, the Administrator would be authorized, through September 30, [illegible], to provide hospital care and other health-care services under this section to any veteran who is eligible for hospital, nursing home, or domiciliary care under section 610 of title 38 or for outpatient services under section 612 and who is determined to be suffering from PTSD attributable to the veterans' service. The Administrator would be authorized to provide hospital care, medical services, outpatient services, counseling to family members and others in primary social relationships with the veteran, rehabilitation services, vocational counseling, home health services, and other services necessary for the treatment of the veteran and to coordinate the provision of these services with readjustment counseling services under section 612A of title 38. The House bill would authorize services under new section [illegible] to be provided only through VA treatment units established for the treatment of PTSD although it would not have affected existing authority to provide such health care under other provisions in title 38. These PTSD treatment units would be required to sponsor educational efforts for public and private sector health-care professionals concerning the causes, diagnosis, and treatment of PTSD and would also be given priority in obtaining VA research funds allocated for the study of PTSD. Any VA medical facility with PTSD treatment services already established by October 1, 1984, would be required to be considered to have a PTSD treatment unit for the purposes of new section [illegible] unless the Administrator were to determine that such services were unnecessary at that facility or that the VA could more efficiently meet the demand for PTSD treatment at another facility.

The compromise agreement contains a provision (section 110(a)) derived from these provisions. Under the compromise agreement, the Chief Medical Director would be authorized to designate special programs for the treatment of PTSD and would be required to direct any such designated PTSD programs to include in their efforts the provision of the education and the training of VA and non-VA health-care personnel in the causes, diagnosis, and treatment of PTSD and (where appropriate) to coordinate PTSD treatment services with readjustment counseling services provided under present section 612A of title 38.

The Senate amendment (section 5(a)), but not the House bill, would require the VA's Chief Medical Director (CMD) to establish a Special Committee on PTSD in the Department of Medicine and Surgery (DM&S) and to appoint qualified DM&S employees to serve on the Special Committee. The Special Committee would be required to assess the VA's capacity to provide diagnosis and treatment to eligible veterans with PTSD and to advise the CMD on policies, guidance, and coordination of services for the diagnosis and treatment of veterans with PTSD by VA programs, including inpatient PTSD units, other psychiatric programs, outpatient mental health clinics, and readjustment counseling programs. The Special Committee would also be required to make recommendations to the CMD on guidance for appropriate diagnosis and treatment of veterans with PTSD by VA programs, including inpatient PTSD units, other psychiatric programs, outpatient mental health clinics, and readjustment counseling programs. The Special Committee would also be required to make recommendations to the CMD on guidance for appropriate diagnostic and treatment methods, referral for and coordination of follow-up programs, the conduct of research on PTSD, education and training on PTSD for VA employees, the allocation of resources for all VA PTSD activities, and steps to improve the diagnosis and treatment of PTSD and the operation of inpatient PTSD units.

The compromise agreement contains these provisions (section 110(b)).

The Senate amendment (section 5(b)), but not the House bill, would require the CMD to establish and operate a National Center on PTSD (1) to conduct and promote research on, and the training of health-care and related personnel in, the diagnosis and treatment of veterans with PTSD, and (2) to serve as a resource center for the coordination and exchange of information on VA and other research and training activities with respect to PTSD. The House bill would require the Administrator to promote the exchange of information among health-care professionals concerning PTSD.

The compromise agreement contains the Senate provisions (section 110(c)).

The House bill, but not the Senate amendment, would require the Administrator to compile and publish, on regular basis, research results on the causes, diagnosis, and treatment of PTSD.

The compromise agreement contains this provision (section 110(d)), with a modification so that the CMD, not the Administrator, would be required to compile and publish the research results.

The House bill, but not the Senate amendment, would require the Administrator to identify in the President's budget for each fiscal year during the operation of the PTSD treatment units proposed in the House bill, the resources allocated to the units and to give priority, when feasible and otherwise appropriate, to medical facilities with PTSD units when allocating research funds related to PTSD.

The Senate amendment (section 5(c)), but not the House bill, would require the Administrator to report to the Committees within 180 days after the date of enactment, on the implementation of the Senate amendment provisions relating to the Special Committee and the National Center. The report would include a list of the members of the Special Committee; the CMD's assessment of the VA's capability to meet the needs of certain veterans with PTSD; a description of the results of any evaluations of inpatient PTSD units; the Special Committee's plans for further assessments; the Special Committee's recommendations to the CMD; a description of the implementation of these provisions; and the Administrator's assessment of the VA's capacity to meet the needs of certain veterans (Vietnam veterans, former prisoners of war, and other veterans with PTSD eligible for VA health care), as well as the Administrator's plans, a timetable, and costs for increasing that capacity. Not later than February 1, 1986, and annually thereafter, the VA would be required to submit a report to the Committees updating this information.

The compromise agreement contains a provision (section 110(d)) derived from these provisions. Under the compromise agreement, the Administrator would be required to submit, not later than March 1, 1985, to the Committees a report on the implementation of the new PTSD provisions. This report would include a list of the members of the Special Committee; a list of all specialized and other PTSD programs; a description of the resources allocated for each program; a description of the training provided to personnel on PTSD; and the specification of the funding allocated to support research on PTSD. In addition, the report would include the CMD's assessment of the VA's capability to meet the need for PTSD diagnosis and treatment of certain veterans and the efficacy of the treatment provided and a description of the results of PTSD program evaluations; the Special Committee's plans for further assessments of the VA's capability to diagnose and treat veterans with PTSD; the Special Committee's recommendations to the CMD and the CMD's views on these recommendations; a summary of the results of VA-conducted research on PTSD; a description of steps taken, plans made, and resources to be applied to implement the provisions relating to the Special Committee and the National Center; and the Administrator's assessment of the VA's capacity to meet the needs of certain veterans for PTSD diagnosis and treatment and any plans, including costs, of increasing that capacity. Not later than February 1, 1986, and February 1 of each year for the following three years thereafter, the Administrator shall submit to the House and Senate Veterans' Affairs Committees a report updating the reports previously submitted.

With respect to the portions of these reports relating to the allocation of resources for PTSD programs, treatment, and research, the Committees intend the first report to include information with respect to allocations made for fiscal year 1985 and expenditures for each prior year. The Committees intend that each subsequent report provide updating information through allocations made for the fiscal year in which the report is submitted.

ALCOHOL AND DRUG TREATMENT AND REHABILITATION GUIDELINES

The Senate amendment (section 3), but not the House bill, would amend present section 620A of title 38, relating to treatment and rehabilitation for alcohol or drug dependence or abuse disabilities, to require the Administrator, not later than 12 months after the date of enactment, to prescribe regulations providing guidelines for treatment and rehabilitation of veterans for alcohol or drug dependence or abuse disabilities in VA facilities. The guidelines would be required to include guidance on the duration of treatment and rehabilitation (taking into account the duration of such treatment and rehabilitation in non-VA programs and identifying duration in detoxification, inpatient-acute care, inpatient-rehabilitation care, inpatient-extended care, outpatient care, and follow-up services), referral assistance, and monitoring of individual treatment plans and follow-up.

The compromise agreement contains a provision (section 303) derived from this provision. Under the compromise agreement, the Administrator would be required to issue, not later than six months after the date of enactment, guidelines for the treatment and rehabilitation of veterans for alcohol or drug dependence or abuse disabilities, under chapter 17 of title 38, in VA facilities and submit to the Committees a copy of the guidelines and a report on the implementation of this section.

The Committees intend that, in the development of the guidelines, the Administrator consider the subject matter covered in the Senate amendment.

The Senate amendment, but not the House bill, would also require the Administrator to submit, not later than March 1, 1985, and March 1 of each subsequent year, to the Committees, a report containing a comprehensive survey of activities during the preceding fiscal year of all VA alcohol or drug dependence or abuse treatment and rehabilitation programs.

The compromise agreement does not contain this provision.

The Senate amendment, but not the House bill, would also amend present section 620A of title 38, to delete the reference to "pilot" in the description of the VA's program for the provision of alcohol and drug treatment and rehabilitation through contracts with non-VA halfway houses and other community-based programs, to extend for two years, through September 30, 1987, the VA's authority to contract with such halfway houses and other programs, and to require the Administrator to submit to the Committees, not later than March 1, 1986, a report on the operation of the contract program (including information on the average duration of veterans' participation, the rates of successful rehabilitation, and any changes in average and maximum costs per veteran under the contracts entered into by the VA).

The compromise agreement does not contain these provisions.

The Committees note that this contract authority is not due to expire until September 30, 1985, and that the House Committee tentatively plans to hold hearings next year on the VA's programs for treatment and rehabilitation for veterans with alcohol and drug abuse disabilities, including the halfway house program.

REPORT ON VETERANS' ADMINISTRATION PROGRAMS FOR TERMINALLY ILL VETERANS

The Senate amendment (section 4), but not the House bill, would require the Administrator, not later than September 30, 1985, to submit to the Committees a report on VA programs to furnish palliative care, supportive counseling, and other medical services to terminally ill veterans and supportive counseling to their families.

The compromise agreement (section 301) contains this provision but deletes a reference to the Administrator including in the report any proposals of the Administrator for administrative or legislative action in this area.

VETERANS RESIDING IN REMOTE GEOGRAPHIC AREAS

The Senate amendment (section 13), but not the House bill, would express the sense of the Congress that, in light of the geographic inaccessibility to VA health-care facilities of certain veterans with service-connected disabilities and other veterans eligible for VA health care, a study of veterans residing in remote areas and their use of VA health-care facilities would provide useful information on the feasibility and appropriateness of alternative approaches to health-care services for such veterans. The Administrator would be required to carry out such a study and, not later than January 1, 1986, submit to the Committees a report on the study results. Not later than July 1, 1986, the Administrator would be required to submit a report to the Committees on an experimental program to demonstrate in 5 remote areas alternative approaches for the VA to provide health-care services to eligible veterans in remote areas.

The compromise agreement (section 302) contains these provisions.

USE OF CERTAIN LANDS BY THE UNIVERSITY OF CALIFORNIA

Both a related House bill (H.R. 3939 as passed by the House on November 8, 1983), and the Senate amendment (section 14) would require the Administrator to execute any necessary legal documents to permit the use, for educational or cultural purposes, of a portion of certain property in Los Angeles, California. When this land was originally transferred to the State of California on December 10, 1948, for use by the University of California, the deed limited its use to use as a research and medical center and for allied purposes. Under the revised deed, the property involved would revert to the United States if it ceases to be used as a research and medical center or for educational or cultural purposes.

The compromise agreement (section 401) contains this provision.

NAMING OF VETERANS' ADMINISTRATION MEDICAL CENTERS

The Senate amendment (section 15(a)), but not the House bill, would designate the VA Medical Center in Murfreesboro, Tennessee, as the "Sergeant Alvin C. York VA Medical Center".

A related House bill (H.R. 4734 as passed by the House on May 21, 1984) and the Senate amendment (section 15(b)) would designate the VA Medical Center in Milwaukee, Wisconsin, as the "Clement J. Zablocki VA Medical Center".

The compromise agreement (section 402) contains these provisions with a modification to delete the word "Sergeant" from the proposed new name of the VA Medical Center in Murfreesboro, Tennessee.

AUTOMOBILE ADAPTIVE EQUIPMENT

The Senate amendment (section 7), but not the House bill, would amend section 1902(c) of title 38, to specify that veterans eligible for adaptive equipment for their automobiles are entitled to a maximum of two such adaptations at any one time or within a 4-year period unless, as a result of circumstances beyond the veteran's control, the veteran no longer has use of one of those two vehicles, in which case the Administrator would be authorized to provide the veteran with an adaptation for a third vehicle.

The compromise agreement does not contain this provision.

The Committees intend to consider the Senate provision in relation to a House provision (section 204) in H.R. 5688, the proposed "Veterans' Compensation Amendments for Fiscal Year 1985", when the provisions of that measure are resolved in relation to the provisions of S. 2720, the proposed "Veterans' Administration Benefit Rate Increase and Program Improvement Act of 1984".

PER DIEM RATES FOR STATE HOMES

The House bill (section 3), but not the Senate amendment, would amend section 641(c) of title 38, relating to payments to State Homes, to require the Administrator to submit annually to the Committees a report on the adequacy of the per diem rates (prescribed by current section 641(a)) paid by the VA to the State for veterans who are receiving domiciliary, nursing home, or hospital care in State Veterans' Homes. Under present section 641(c), the Administrator is required to submit such a report every three years beginning on June 30, 1983.

The compromise agreement does not contain this provision.

VETERANS AUTHORIZED TO BE FURNISHED WITH DRUGS AND MEDICINES

The House bill (section 6), but not the Senate amendment, would amend section 612(h) of title 38, relating to the eligibility for certain medical treatment, to authorize the Administrator to provide a veteran with drugs and medicines prescribed by a private physician for the treatment of a service-connected disability for which the veteran is receiving compensation.

The compromise agreement does not contain this provision.

READJUSTMENT COUNSELING

The Senate amendment (section 8), but not the House bill, would amend section 612A(g)(2)(B) of title 38, to require the Administrator to include in a previously mandated VA report on the effectiveness and the future of the VA's readjustment counseling program for Vietnam-era veterans—due to be submitted to the Committees not later than April 1, 1987—assessments of whether or not certain veterans and certain active-duty personnel who are not currently eligible for readjustment counseling under section 612A need such counseling, and, if so, the Administrator's recommendations on how such needs should be met.

The Senate amendment, but not the House bill, would also require the Administrator and the Secretary of Defense to submit, not later than 180 days after the date of enactment, to the appropriate committees of the Congress a joint report on their recommendations on the appropriateness and desirability of extending eligibility for VA readjustment counseling services to persons who served on active duty either during the Vietnam era or after the Vietnam era in an area of hostilities.

The compromise agreement does not contain these provisions.

REPORT ON FEDERAL GOVERNMENT RESPONSIBILITY TO INDIVIDUALS WHO SERVED WITH VOLUNTARY CIVILIAN ORGANIZATIONS IN VIETNAM

The Senate amendment (section 11), but not the House bill, would require the Administrator and the Secretaries of Defense and of Health and Human Services to submit to the appropriate Congressional committees, not later than 180 days after the date of enactment, a joint report on the question of U.S. Government responsibility for providing benefits and services (including, but not limited to, health care and monetary compensation for disabilities which may be related to exposure to dioxin or be the result of traumatic events), either through the VA or otherwise, to individuals who served in Vietnam with voluntary organizations that provided significant assistance to the U.S. Armed Forces and who incurred disabilities that may be related to such service.

The compromise agreement does not contain this provision.

SENSE OF THE CONGRESS REGARDING CERTAIN GRACE COMMISSION RECOMMENDATIONS

The Senate amendment (section 10), but not the House bill, would express the sense of the Congress (1) that the recommendations of the President's Private Sector Survey on Cost Control (the "Grace Commission") relating to the VA health-care system must be evaluated in light of (A) the commitment of the United States, as embodied in the VA's Department of Medicine and Surgery, to meet the medical needs of veterans eligible for health care from the VA, especially veterans with service-connected disabilities, (B) the policy of the United States to maintain a comprehensive, nationwide health-care system for the direct provision of quality health-care services to eligible veterans, and (C) the requirement, pursuant to section 5010(a)(1) of title 38, United States Code, for the VA to operate and maintain not less than 90,000 hospital and nursing home beds, and (2) that the recommendations should not be implemented without full and careful consideration of their policy implications by the Committees.

The compromise agreement does not contain this provision.

PROGRAM GUIDE ON ALZHEIMER'S DISEASE

The Senate amendment (section 16), but not the House bill, would require the Administrator to provide, not later than 180 days after the date of enactment, to appropriate VA medical facilities and to submit to the Committees a program guide to clarify VA policy regarding the authorization and provision of treatment for Alzheimer's disease, (including diagnosis, information, outpatient services, hospital care, and nursing home care, of veterans who are eligible for services under title 38, United States Code, and who are suffering from Alzheimer's disease and related neurological diseases).

The compromise agreement does not contain this provision.

Mr. CRANSTON. Mr. President, as the ranking minority member of the Committee on Veterans' Affairs, I am delighted to join with my good friend, the committee chairman [Mr. SIMPSON], in urging the Senate to concur in the House amendments to the Senate amendments to H.R. 5618, the proposed Veterans' Health Care Act of 1984. The House amendment to the text of the bill reflects a compromise agreed to between the two Veterans' Affairs Committees after extensive discussions and negotiations. This is an important measure that will help maintain and improve the quality, scope, and efficiency of the benefits and services provided to those who have worn our country's uniform in defense of our national security.

Mr. President, H.R. 5618 was first passed by the House on May 21, 1984. On August 8, 1984, the Senate took up S. 2514 as reported by the Committee on Veterans' Affairs on May 23. The Senate substituted the provisions of S. 2514 as an amendment to the text of H.R. 5618 as passed by the House and then passed H.R. 5618, returning it to the House. Yesterday, the House of Representatives amended the Senate amendment with a substitute which, as I just noted, represents a compromise agreement reached by the Veterans' Affairs Committees. Hence, this legislation before the Senate today is in the nature, although not the form technically, of a conference report.

The measure is a compromise and, as with all compromises, it does not contain all of the provisions each of the parties would like to have included. In fact, because the bills passed by the two Houses had little common ground, many provisions—some of which I will describe in a moment—were dropped in reaching the final agreement. Nevertheless, this measure as it comes before the Senate today represents, I am convinced, the best deal that the Senate could obtain in resolving the differences between the two Houses.

BACKGROUND

Mr. President, I am pleased that this legislation, which I will refer to as the compromise agreement, is the culmination of the legislative process for S. 2300 which I introduced on February 7, 1984, with the cosponsorship of Senators RANDOLPH, MATSUNAGA, and DECONCINI, and amendment No. 2880 which I proposed with Senator MATSUNAGA on March 27. I refer my colleagues and others with an interest in the background and development of the provisions of S. 2300 and amendment No. 2880 to my remarks upon introduction of those two measures—beginning on page S1064 of the RECORD for February 7, 1984, for S. 2300 and on page S3346 of the RECORD for March 27, 1984, for amendment No. 2880—and my remarks at the time of Senate action on S. 2514, which begin on page S10117 of the RECORD for August 8, 1984.

Mr. President, I am very grateful to our committee chairman [Mr. SIMPSON] and the chairman [Mr. MONTGOMERY] and ranking minority member [Mr. HAMMERSCHMIDT] of our counterpart committee in the House and to the chairman of the House committee's Hospitals and Health Care Subcommittee [Mr. EDGAR] for their cooperation and assistance in the development of the compromise agreement.

Mr. President, each of the provisions of the compromise agreement is described authoritatively in the explanatory statement developed by the two Committees on Veterans' Affairs that the chairman of the Senate committee has inserted in the RECORD as part of his remarks and which was inserted in identical form by the chairman of the House committee when this measure was considered in the other body yesterday. I wish to highlight certain elements of the compromise agreement.

SECURITY AND LAW ENFORCEMENT AT VA FACILITIES

Mr. President, I am very pleased that the compromise agreement contains a number of provisions derived from legislation I proposed to enable the VA to improve its recruitment, retention, and management of security service personnel. As I noted during Senate consideration of this legislation on August 8, the record is clear—the VA is and has been experiencing significant difficulties in attracting and, more importantly, keeping qualified security personnel. In far too many areas of the country, the VA police force serves as the training ground for individuals who are interested in careers in police or security work but who leave the VA as soon as they acquire the experience they need to obtain jobs with higher pay and greater potential for advancement. The new authorities in the compromise agreement should go a long way toward helping to solve these problems and, thus, should yield significant improvements in overall security at VA health-care facilities.

The two most important of these provisions would give the Administrator new authorities to modify rates of pay for VA police officers and to pay a special clothing allowance to uniformed officers.

The first of these provisions in the compromise agreement—derived from section 6 of S. 1388—relating to rates of pay would provide the Administrator with new authority to increase the rates of basic pay for VA police officers where that is necessary either to provide rates of pay competitive with the rates paid by non-Federal employers in the same labor market, to achieve adequate staffing at particular facilities, or to recruit persons with specialized skills. This authority could be exercised on a nationwide, local, or other geographic basis, thereby giving the Administrator maximum flexibility to set rates of pay in response to local situations and conditions.

The second provision in the compromise agreement that should have the greatest impact on the agency's ability to recruit and retain police officers would authorize the Administrator to pay a uniform allowance to those VA police officers required to wear a uniform in the performance of official duties. These provisions—derived from amendment No. 2880 which I submitted on March 27—would authorize the payment of a one-time, up-to-$400 allowance either at the time an individual is first employed as a VA police officer for those hired after this measure becomes law, or upon request, for police officers already employed by the VA, so as to assist with an initial purchase of uniforms. In all other years, an allowance would be paid of up to $200 to help these personnel replace and maintain their required uniforms. These allowances would replace the inadequate $125 annual allowance that VA police officers currently receive.

No one should have to suffer a financial disadvantage to work as a VA police officer, and I expect that the uniform allowance proposed in the compromise agreement will help correct this situation.

Mr. President, the issue of improving security at VA health-care facilities has been one that has been of particular concern to the members of our committee and our counterparts in the House, particularly my good friend from Pennsylvania, Bob Edgar. It has been very gratifying to work with them as we have crafted this legislation as it comes before the Senate today to address this very troublesome problem. I look forward to monitoring the VA's efforts to implement the new authorities and to the results of those efforts in terms of real improvement in the recruitment and retention of VA security personnel.

POST-TRAUMATIC-STRESS DISORDER

Mr. President, another issue that has been of great concern to me and to members of both committees and is addressed in the compromise agreement relates to the VA's efforts to diagnose and treat veterans with post-traumatic-stress disorder (PTSD).

As I noted in my remarks when I introduced amendment No. 2880 on March 27, 1984—at S3380 of the Record—and during Senate consideration of S. 2514 on August 8, 1984, inasmuch as PTSD is a disorder that is particularly prevalent among veterans and especially among Vietnam combat veterans, I believe the VA has a very strong obligation to be at the forefront of efforts to understand and treat PTSD. As I also discussed in some detail in those remarks, although the VA has made some strides in this area, I am concerned that the agency could and should be doing more and doing it in a far better coordinated fashion.

Thus, I am very pleased that the compromise agreement melds provisions relating to PTSD from both the House and Senate measures. Under the compromise agreement, the VA will be authorized to designate programs within the agency—such as existing inpatient PTSD treatment units or outpatient programs—as special PTSD units which would have a particular responsibility for the diagnosis and treatment of PTSD, the promotion of education and training of other health-care personnel regarding PTSD diagnosis and treatment, and the coordination of treatment services with the VA's vet centers. I particularly stress the importance of the last item.

In addition, the VA's Chief Medical Director would be required to establish a Special Committee on PTSD as well as a National Center on PTSD. The special committee, proposed by our committee chairman, would assess the agency's efforts relating to PTSD, including through the Vet Center Program, and advise the Chief Medical Director regarding policies relating to PTSD. The National Center, which I first proposed in amendment No. 2880, would carry out and promote research into PTSD, train health-care personnel in the causes and diagnosis of PTSD, and serve as a resource center to coordinate exchange of information regarding PTSD research and training activities. Obviously, coordination between the special committee and the national center would be very important. Both, of course, will operate under the direction of the Chief Medical Director which should promote such coordination. In order further to improve this relationship, I would anticipate that the Director of the national center would serve as a member of the special committee.

I believe the collective impact of these PTSD provisions will be to focus and, as necessary and appropriate, expand and improve the VA's efforts to respond to veterans suffering from PTSD, including greater coordination of ongoing efforts, especially those efforts of the vet centers.

PROGRAMS FOR OLDER VETERANS

Mr. President, various provisions in the compromise agreement relate directly—but not exclusively—to the VA's ongoing efforts to meet the health care needs of our Nation's aging veterans, particularly in light of the large number of World War II veterans who are now approaching an average age of 65.

COORDINATION OF VA HEALTH-CARE SERVICES

First, the compromise agreement contains a provision, derived from the Senate amendment provision authored by our committee chairman, which directs the Administrator to seek to coordinate VA benefits and services with appropriate State and local government programs, and programs conducted by private entities at the State and local levels. In carrying out this responsibility, the Administrator would be required to place a special emphasis on veterans who are 65 years of age or older.

Mr. President, this new coordination responsibility should provide the VA with important new opportunities to foster VA-community cooperative efforts that could play a very important role in enabling local VA and non-VA facilities involved in providing services to veterans to respond in a more effective, better coordinated fashion to the needs of those veterans.

On this point of interagency cooperation, I note that, when the Senate considered legislation—S. 2603, the Older American Act Amendments of 1984—to reauthorize the Older Americans Act of 1965, a provision was included which would have had the effect of requiring the Administrator of Veterans' Affairs to consult with the Commissioner on Aging with respect to any new veteran's programs or service prior to establishing it and to consult and cooperate with the Commissioner in carrying out each VA program.

Mr. President, although I am generally supportive of consultation and appropriate cooperation and coordination among Federal departments and agencies involved in providing similar services or benefits to different or overlapping populations—and for this reason supported the provision in the pending compromise agreement relating to the coordination of VA benefits and services—I was opposed to the very specific and broad requirements for advance consultation and for ongoing coordination, consultation, and cooperation that the provision in S. 2603 as proposed by the Committee on Labor and Human Resources and passed by the Senate would have imposed on the VA Administrator.

Because of my views in this regard, I wrote the distinguished chairman of the Committee on Labor and Human Resources [Mr. Hatch] to urge that the Senate conferees on S. 2603 recede to the House with respect to this provision.

I am pleased to note that the conference report on S. 2603 (H.R. Rept. No. 98-1073, page 33) did not include this provision, and I wish to thank the Senator from Utah and the other Senate conferees very much for their assistance in this regard. This result leaves the impetus for coordination of VA benefits and services with the VA Administrator and under the authority of title 38, United States Code, and the Committee on Veterans' Affairs. The provision in the pending compromise agreement relating to such coordination is the latest example of such title 38 authority.

Mr. President, I ask unanimous consent that the text of my letter to Senator HATCH be printed at this point in the RECORD.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

WASHINGTON, DC,
August 30, 1984.

Hon. ORRIN G. HATCH,
Chairman, Committee on *Labor and Human Resources, U.S. Senate, Washington, DC.*

DEAR ORRIN: As the Ranking Minority Member of the Committee on Veterans' Affairs, I am writing to express concerns that I have about S. 2603, the proposed "Older Americans Act Amendments of 1984", currently pending in conference.

Specifically, I am writing with respect to the provision in section 3(d) of the Senate-passed bill. This provision would have the effect of requiring the Administrator of Veterans' Affairs, under section 203 of the Older Americans Act (OAA), to consult with the Commissioner on Aging with respect to any new veterans' program or service prior to establishing it and, in order to "achieve appropriate coordination," to "consult and cooperate with the Commissioner in carrying out" each VA program. (Under the new clause (14) of OAA section 203 that would be added, the Secretary of Labor would have the same kinds of responsibilities with respect to veterans' employment programs authorized by title 38, "Veterans' Benefits and Services", United States Code, and the concerns I have regarding VA programs under this legislation extend to Labor Department (DOL's 38 programs also.)

I generally support consultation—and, where appropriate, cooperation and coordination—among Federal departments and agencies involved in providing similar services or benefits to different or overlapping population groups. Indeed, as a member of the Veterans' Affairs Committee and for 13 years the Labor Committee, I have written numerous such provisions that have been enacted into law requiring that an agency under the jurisdiction of a particular Committee seek to consult and coordinate with other concerned agencies. These include a provision, section 220 of title 38, United States Code, generally requiring the VA Administrator to seek to achieve the maximum feasible coordination of Federal programs and activities affecting veterans and their dependents.

Although I support interagency cooperation, I am opposed to the very specific and broad requirements for advance consultation and for ongoing coordination, consultation, and cooperation that section 3(d) would impose on the Administrator. A primary concern in this regard is that, in light of the breadth of OAA section 203 and the fact that the Commissioner on Aging, appropriately, has no responsibility for the conduct of veterans' programs and has vast responsibilities with respect to a wide range of non-veterans' programs, compliance with the proposed mandate could result in delays in, and other impediments to, the prompt and efficient implementation of veterans' programs.

I also note in this regard that, on page 18 of the recently released VA report, "Caring for the Older Veteran", the VA states its objective to establish at each of its medical centers a Community Collaboration Office "charged with responsibility for linking VA programs for the aging with those in the community." I support that concept just as I support the provision, in section 2 of S. 2514 as reported by our Committee on May 24, 1984, and passed by the Senate on August 8, requiring the designation in each VA medical center of a unit to promote the coordination of referrals and services at the local level. I intend to continue to pursue the enactment of legislation requiring the VA to seek to coordinate its older veterans' activities appropriately at the local level.

In my view, however, any legislation to encourage or require the VA to consult with other Federal agencies or to seek to coordinate VA services with theirs should be considered and acted upon as part of title 38 of the United States Code—not as part of the laws authorizing and governing the other agencies. Thus, I urge that, in conference with the House on S. 2603, the Senate conferees recede to the House with respect to the provision, in section 3(d) of the Senate-passed measure, relating to title 38 veterans programs.

Thank you very much for your consideration of this matter. If you have any questions, please have a member of your staff contact Bill Brew (42074) of the Veterans' Affairs Committee staff.

With warm regards.
Cordially,

ALAN CRANSTON,
Ranking Minority Member.

AUTHORIZATION OF APPROPRIATION FOR THE GRECC PROGRAM

Mr. CRANSTON. Mr. President, the second provision in the compromise agreement relating to the VA's efforts to meet the health-care needs of aging veterans would make permanent the authorization of appropriations to support the research and education activities of the VA's Geriatric Research, Education, and Clinical Centers—the GRECC program. Under current law, the authorization of appropriations for these purposes is only available through fiscal year 1984.

As the Senate author of the provisions in Public Law 96-330 which provide a statutory basis for the GRECC program, I have a very strong interest in this program. It is through the GRECC program that the VA exerts a very important leadership role in advancing scientific knowledge regarding the medical, psychological, and social needs of older individuals and how to meet such needs with the most effective and appropriate services. In the GRECC program, the VA carries out geriatric and gerontological research, trains health personnel in the provision of health care to older individuals, and develops improved models of clinical services for eligible older veterans.

Although the GRECC program would continue to operate without this renewal of a specific authorization of appropriations, I believe that continuing to provide such an authorization specifically for the research and education efforts in the program highlights the importance of these elements and demonstrates continuing congressional support for the GRECC program. Thus, I am pleased to support this provision.

ACQUISITION OF PROPERTIES FOR USE AS STATE HOMES

A third provision in the compromise agreement that is of particular importance to the agency's overall efforts to respond to the health-care needs of the aging veteran population would authorize the VA to provide financial assistance, under the VA's State veterans' home matching-fund construction grant program, to a State to enable the State to acquire an existing facility for use as a State veterans' home nursing home or domiciliary facility. It is the VA's view that, under current law, such grants can be made to States for the construction of new nursing home or domiciliary facilities but not for the acquisition of such facilities. Because the State home program is such a vital adjunct to the agency's efforts to provide extended care for older veterans, I am delighted that the compromise agreement contains this provision to remove the unnecessary restriction on how States may utilize grant funds.

OVERSIGHT OF VARIOUS VA HEALTH CARE MATTERS

Mr. President, the compromise agreement contains a number of provisions which are intended to assist our two committees in carrying out our ongoing oversight of the VA health care system. Among those provisions are ones that would require the Administrator of Veterans' Affairs:

First, to issue guidelines, not later than 6 months after the date of enactment, for the treatment and rehabilitation of veterans with alcohol or drug dependence or abuse disabilities and to report to the committees on this effort.

Second, to report to the committees, not later than September 30, 1985, on the VA's efforts to provide care and services to terminally ill veterans and supportive counseling to members of their families.

Third, to study and report to the committees, not later than January 1, 1986, on the extent to which veterans residing in areas remote from VA health-care facilities receive health care from the VA and to submit a second report, by July 1, 1986, providing a description of an experimental program that could be carried out in five remote areas to demonstrate alternative approaches which the VA might use to provide health care to eligible veterans in such areas.

Also, I note that, in connection with the "temporary" extension, which is contained in this compromise agreement, for the fourth consecutive time of the VA's extraordinary authority to provide health care, on a contract basis, to certain non-service-connected veterans in Puerto Rico and the Virgin Islands, the committees have directed the Administrator to submit a thorough plan on how the VA will meet the health-care needs of eligible veterans in those locations with particular attention to the needs of veterans with service-connected disabilities.

These various oversight provisions should yield important information that the committees can utilize as we continue in our efforts to improve and strengthen the overall VA health-care system. Regarding the rural veterans' health-care study and report, I want to congratulate my colleague and fellow committee member from Maine (Mr. MITCHELL) for his outstanding, persistent, and perceptive work on behalf of this legislation.

SENATE-PASSED PROVISIONS NOT INCLUDED IN THE COMPROMISE AGREEMENT

Mr. President, as I noted earlier, in reaching the agreement embodied in the compromise agreement, we were unable to reach agreement on a number of provisions that were passed by either the House or Senate but not by the other body. I wish to comment on a few of the Senate-passed provisions that are not included in the compromise agreement.

READJUSTMENT COUNSELING REPORTS

Mr. President, I am very disappointed that the compromise agreement does not include provisions, derived from legislation I introduced, which would have mandated the submission by the VA of two reports—one in conjunction with the Department of Defense—assessing the need for and access to readjustment counseling from the VA for certain veterans and certain active-duty personnel, including those who have served since the end of the Vietnam era in combat and combat-like situations, such as in Beirut and Grenada, who are not currently eligible for such services. I remain very concerned that there may be a generally unappreciated need for the type of assistance that can best be provided through the VA's readjustment counseling program for some veterans and active-duty personnel in the groups that would have been studied and believe our failure to investigate that possibility is very shortsighted. Although I was not successful in convincing the House committee to accept the Senate provision to mandate study of these issues, I intend to continue to pursue them.

REPORT ON FEDERAL GOVERNMENT ASSISTANCE TO INDIVIDUALS WHO SERVED IN VIETNAM AS CIVILIANS

I also want to express my further regret that the compromise agreement does not contain a provision that was included in the Senate amendment and that was derived from legislation I authored to attempt to address the concerns of non-Federal civilians who served in Vietnam during the Vietnam era with voluntary organizations, such as the Red Cross and the USO. As I noted during Senate consideration of S. 2514, certain civilians who, through their service, provided valuable assistance to the U.S. Government's efforts in Vietnam are now concerned about the effects of certain incidents of their service, such as their exposure to agent orange, on their health. I believe the Federal Government has an obligation to evaluate those concerns and consider possible alternative approaches for addressing them. In taking this position, I recognize that these individuals are not veterans and that there is thus no basis for the VA to assume primary responsibility for addressing their concerns. Having said that, however, I continue to believe that the VA has significant expertise to lend to the resolution of the issue and should play a role in any such effort by the Federal Government. Unfortunately, we were unable to bring the other body to this point of view.

ALCOHOL AND DRUG TREATMENT AUTHORITY

Mr. President, the Senate amendment contained various provisions relating to the VA's program for the treatment and rehabilitation of veterans suffering from alcohol or drug dependence or abuse disabilities. As noted above, the compromise agreement contains provisions—derived from provisions authored by our Chairman [Mr. SIMPSON] in the Senate amendment—pertaining to the issue of VA central office guidance to field stations in this respect. Not included, however, are provisions from the Senate amendment derived from legislation, S. 2366, I introduced to extend the VA's pilot program for the provision of alcohol and drug treatment or rehabilitation through contracts with non-VA halfway house and other community-based programs. On the basis of information currently available on the experience under this 5-year pilot program—which I authored as part of Public Law 96-22—since its establishment in 1979, I believe that the 3-year extension provided for in the Senate amendment was fully justified and appropriate. Thus, I regret that this extension is not included in the compromise agreement. However, the program does not expire until September 30, 1985, so there is still some time to extend it. I intend to introduce in the next Congress legislation to extend the program for 3 years and will work for its enactment as early as possible next year.

REVIEW OF CERTAIN HEALTH-CARE-RELATED GRACE COMMISSION RECOMMENDATIONS

Mr. President, another provision included in the Senate amendment but not in the compromise agreement would have put the Congress on record with reference to the need for detailed study before any action on certain recommendations—all relating to the VA health-care system—of the President's Private Sector Survey on Cost Control, the so-called Grace Commission. This provision, which was derived from legislation which I cosponsored as introduced by my good friend from Arizona [Mr. DECONCINI] would have been helpful in reaffirming the commitment of the Congress to the maintenance of the VA health-care system. I therefore regret that we were unable to reach agreement to include such a provision in the compromise agreement.

PROGRAM GUIDE ON ALZHEIMER'S DISEASE

Mr. President, the last provision I want to note from the Senate amendment that is not included in the compromise agreement would have required the Administrator of Veterans' Affairs to disseminate to appropriate VA health-care facilities and submit to the Committees on Veterans' Affairs a program guide on Alzheimer's disease and related neurological diseases. This provision was included in the Senate amendment on behalf of my good friend from Ohio [Mr. METZENBAUM] and reflected his and my strong personal concern about the issue of Alzheimer's disease. I have had for some time a deep interest in the VA finally issuing a program guide on Alzheimer's disease so as to provide a more widespread understanding of VA policy in this area. Over 2 years ago when I first pursued this matter with the VA's Chief Medical Director, I was advised that such a guide was under development. It is long since past time for its issuance. Although the provision relating to this guide is not in the compromise agreement, I intend to continue to press for administrative action on this matter.

CONCLUSION

In closing, I would like to express my appreciation to the Chairman [Mr. SIMPSON] and all of the other members of the committee for their cooperation and assistance as we have worked to develop this compromise. I also thank again my good friends on the House Committee, the chairman of the full committee [Mr. MONTGOMERY], the ranking minority member of both the full committee and the Hospitals and Health Care Subcommittee [Mr. HAMMERSCHMIDT], and the chairman of the Hospitals and Health Care Subcommittee [Mr. EDGAR] for their usual fine work and cooperation. As always, it has been a pleasure working with all of our colleagues on our counterpart committee. The compromise measure has true bipartisan support in both Houses.

Mr. President, I also express my warmest thanks to the staff members of the House Committee who played key roles in the development of the compromise agreement, Pat Ryan, Jack McDonnell, Richard Fuller, Rufus Wilson, and, as always, chief counsel and staff director Mack Fleming. To the members of our committee's majority staff, Cindy Alpert, Vic Raymond, Julie Susman, and Tony Principi, and to James MacRae, my thanks for their effective work and cooperation on this measure. As always, I am deeply indebted to our minority staff, Bill Brew, Ed Scott, Jenny McCarthy, Charlotte Hughes, Ingrid Post, and Jon Steinberg, for their excellent assistance.

Mr. President, as I noted at the outset of my remarks, although several provisions passed by the Senate have been deleted in the compromise agreement, I am satisfied that the compromise represents a generally fair resolution of the differences between the measures passed by the two bodies and will contribute substantially to the VA's ability to fulfill its mission, most especially the provision of quality health-care services to eligible veterans. Thus, I commend this compromise to the Senate and urge that it be agreed to unanimously.

Mr. MITCHELL. Mr. President, I want to make a very brief statement regarding H.R. 5618, the Veterans' Health Care Act of 1984, which is now pending before the Senate.

To begin with, I wholeheartedly support this legislation. It contains provisions which make judicious changes in a number of Veterans' Administration programs and authorities which I believe will make significant improvements in the VA's health-care system. I especially want to commend to my colleagues section 302, which deals with VA health-care service availability to veterans residing in remote areas. This section was included in the Senate-passed health care bill this summer; it represented a compromise from original language I introduced in February 1983 dealing with rural health care.

Under section 202, the Administrator will carry out a nationwide study and develop statistics on the number of eligible veterans living various distances from VA medical facilities and their utilization of VA health-care services during fiscal year 1983. The Administrator will be required to submit to the House and Senate Committees on Veterans' Affairs a full report on the study by January 1, 1986. That report will include the Administrator's finding on the extent of the need for the VA to improve health-care services in rural areas.

Following that, the Administrator will be required to submit to those same committees by July 1, 1986, a report describing in detail an experimental national program that would be carried out in five locations to demonstrate alternative approaches that could be used by the VA to provide health-care services to eligible veterans in remote areas and the Administrator's recommendations as to whether any such programs should be carried out.

I am pleased the Senate language was retained in the final agreement on H.R. 5618. I believe the mandated study and report from the Administrator will clearly demonstrate that new, alternative, creative, and innovative methods to deliver VA health care to eligible veterans who reside in geographically remote areas must become reality if those millions of veterans are to receive the care to which they are entitled. Passage of this provision represents not the end, but the continuation of my efforts to improve VA health care for rural veterans all across America.

I am grateful to my colleague from Maine, Senator COHEN; the chairman of the Senate Veterans' Affairs Committee, Senator SIMPSON; and the ranking minority member, Senator CRANSTON, for their assistance and cooperation on this matter.

I urge the adoption of H.R. 5618.

Mr. BAKER. Mr. President, I move that the Senate concur in the House amendments.

The PRESIDING OFFICER. The question is on agreeing to the motion of the Senator from Tennessee.

The motion was agreed to.

APPENDIX E

PUBLIC LAW 98-528—OCT. 19, 1984

VETERANS' HEALTH CARE ACT OF 1984

Public Law 98-528
98th Congress

An Act

Oct. 19, 1984
[H.R. 5618]

To amend title 38, United States Code, to revise and improve Veterans' Administration health programs and to improve security and law enforcement at Veterans' Administration facilities; and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Veterans' Health Care Act of 1984.
38 USC 101 note.

SHORT TITLE; REFERENCES TO TITLE 38, UNITED STATES CODE

SECTION 1. (a) This Act may be cited as the "Veterans' Health Care Act of 1984".

(b) Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

TITLE I—HEALTH PROGRAMS

SECURITY AND LAW ENFORCEMENT AT VETERANS' ADMINISTRATION FACILITIES

38 USC 218.

SEC. 101. (a)(1) Section 218 is amended to read as follows:

"§ 218. Security and law enforcement on property under the jurisdiction of the Veterans' Administration

Regulations.

"(a)(1) The Administrator shall prescribe regulations to provide for the maintenance of law and order and the protection of persons and property on land and in buildings under the jurisdiction of the Veterans' Administration and not under the control of the Administrator of General Services (hereinafter in this section referred to as 'Veterans' Administration property').

"(2) Such regulations shall include—

"(A) rules for conduct on Veterans' Administration property; and

"(B) the penalties, within the limits specified in paragraph (3) of this subsection, for violations of such rules.

Penalties.

"(3) Whoever violates any rule prescribed under paragraph (2)(A) of this subsection shall be fined not more than $500 or imprisoned not more than six months (or such lesser amount or period of time as the Administrator prescribes in the regulations prescribed under this subsection), or both.

"(4) The rules prescribed under clause (A) of paragraph (2) of this subsection, together with the penalties for violations of such rules, shall be posted conspicuously on property to which they apply.

"(5) The Administrator shall consult with the Attorney General before prescribing regulations under this subsection.

"(b)(1) Veterans' Administration employees who are Veterans' Administration police officers shall enforce Federal laws and the rules prescribed under subsection (a)(2)(A) of this section on Veterans' Administration property. Subject to regulations prescribed under paragraph (2) of this subsection, a Veterans' Administration police officer may make arrests on Veterans' Administration property for a violation of any Federal law or of any such rule.

Regulations.

"(2) The Administrator shall prescribe regulations with respect to Veterans' Administration police officers. Such regulations shall include—

"(A) policies with respect to the exercise by Veterans' Administration police officers of the enforcement and arrest authorities provided by paragraph (1) of this subsection;

"(B) the scope and duration of training that is required for Veterans' Administration police officers, with particular emphasis on dealing with situations involving patients; and

"(C) rules limiting the carrying and use of weapons by Veterans' Administration police officers.

"(3) The Administrator shall consult with the Attorney General before prescribing regulations under clause (A) of paragraph (2) of this subsection.

"(4) Rates of basic pay for Veterans' Administration police officers may be increased by the Administrator under section 4107(g) of this title.

"(c)(1) The Administrator may pay an allowance under this subsection for the purchase of uniforms to any Veterans' Administration police officer who is required to wear a prescribed uniform in the performance of official duties.

"(2) The amount of the allowance that the Administrator may pay under this subsection—

"(A) may be based on estimated average costs or actual costs;

"(B) may vary by geographic regions; and

"(C) except as provided in paragraph (3) of this paragraph, may not exceed $200 in a fiscal year for any police officer.

"(3)(A) The amount of an allowance under this subsection may be increased to an amount up to $400 for not more than one fiscal year in the case of any Veterans' Administration police officer. In the case of a person who is appointed as a Veterans' Administration police officer on or after the date on which the Administrator initially exercises the authority granted by this paragraph, an allowance in an amount established under this paragraph shall be paid at the beginning of such person's employment as such an officer. In the case of any other Veterans' Administration police officer, an allowance in an amount established under this paragraph shall be paid upon the request of the officer.

"(B) A police officer who resigns as a police officer less than one year after receiving an allowance in an amount established under this paragraph shall repay to the Veterans' Administration a pro rata share of the amount paid, based on the number of months the officer was actually employed as such an officer during the twelve-month period following the date on which such officer began such employment or the date on which the officer submitted a request for such allowance, as the case may be.

"(4) An allowance may not be paid to a Veterans' Administration police officer under this subsection and under section 5901 of title 5 for the same fiscal year.

"(d) The Administrator shall furnish Veterans' Administration police officers with such weapons and related equipment as the Administrator determines to be necessary and appropriate.

"(e) With the permission of the head of the agency concerned, the Administrator may use the facilities and services of Federal, State, and local law enforcement agencies when it is economical and in the public interest to do so.".

38 USC 218 note.

(2) The provisions of section 218 of title 38, United States Code, other than clause (2) of subsection (a) of such section, as in effect on the day before the date of the enactment of this Act shall remain in effect until the date on which the Administrator of Veterans' Affairs prescribes the regulations required to be prescribed by subsections (a) and (b) of such section as amended by subsection (a) of this section.

(3) The item relating to such section in the table of sections at the beginning of chapter 3 of such title is amended to read as follows:

"218. Security and law enforcement on property under the jurisdiction of the Veterans' Administration.".

97 Stat. 1001.
38 USC 4107.

(b) Section 4107(g) is amended—

(1) in paragraph (1)—

(A) by striking out "or" at the end of clause (A);

(B) by striking out the comma and inserting in lieu thereof a semicolon and "or" at the end of subclause (iv) of clause (B); and

(C) by inserting after clause (B) the following new clause:

"(C) of employees who are Veterans' Administration police officers providing services under section 218 of this title,";

(2) by striking out "health-care" each place it appears in paragraphs (2)(A) and (4); and

(3) by inserting "or (C)" after "(B)" in paragraph (4).

Report.

(c) Not later than one hundred and eighty days after the date of the enactment of this Act, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the implementation of the amendments made by this section. The report shall include (1) the regulations prescribed under section 218 of title 38, United States Code, as amended by subsection (a), and (2) a description of the methodology to be used to determine how the authority provided in the amendments made by subsection (b) is to be exercised.

COMPTROLLER GENERAL REPORT ON MEDICAL PERSONNEL STAFFING LEVELS

Report.
38 USC 5010.

SEC. 102. Section 5010(a)(4)(C) is amended to read as follows:

"(C) Whenever the Director of the Office of Management and Budget is required to submit a certification under subparagraph (B) of this paragraph, the Comptroller General shall submit to the appropriate committees of the Congress a report stating the Comptroller General's opinion as to whether the Director has complied with the requirements of that subparagraph. The Comptroller General shall submit the report not later than fifteen days after the end of the period specified in such subparagraph for the Director to submit the certification.".

CONTRACT HEALTH CARE IN PUERTO RICO AND THE VIRGIN ISLANDS

97 Stat. 730.
38 USC 601.

SEC. 103. (a) Section 601(4)(C)(v) is amended by striking out "September 30, 1984" and inserting in lieu thereof "September 30, 1985".

38 USC 601 note.

(b) Any action by the Administrator of Veterans' Affairs in entering into a contract applicable to the period beginning on October 1, 1984, and ending on the date of the enactment of this Act for the provision of care described in subclause (v) of section 601(4)(C) of title 38, United States Code, and any waiver described in that subclause made by the Administrator that is applicable to that period, is hereby ratified with respect to that period.

EXTENSION OF AUTHORIZATION OF APPROPRIATIONS FOR GERIATRIC RESEARCH, EDUCATION, AND CLINICAL ACTIVITIES

SEC. 104. Section 4101(f)(3) is amended by striking out the first sentence and inserting in lieu thereof the following: "There are authorized to be appropriated such sums as may be necessary for the support of the research and education activities of the centers established pursuant to paragraph (1) of this subsection.". 38 USC 4101.

ACQUISITION OF PROPERTIES FOR USE AS STATE VETERANS' HOMES

SEC. 105. Subchapter III of chapter 81 is amended as follows:

(1) Section 5032 is amended by inserting "(or to acquire facilities to be used as State home facilities)" after "State home facilities". 38 USC 5032.

(2) Section 5034 is amended by inserting "or acquired" after "constructed" each place it appears. 38 USC 5034.

(3) Section 5035 is amended— 38 USC 5035.

(A) by inserting "(or acquisition of a facility to be used as a State home facility)" in the first sentence of subsection (a) after "State home facilities";

(B) by inserting "(or of the estimated cost of facility acquisition and construction)" in clause (1) of subsection (a) after "cost of construction";

(C) by inserting "(or for facility acquisition and construction of the project)" in clause (6) of subsection (a) after "construction of the project";

(D) by striking out "sections 276a through 276a-5 of title 40" in clause (8) of subsection (a) and inserting in lieu thereof "the Act of March 3, 1931 (40 U.S.C. 276a—276a-5)";

(E) by striking out "and" at the end of clause (7), by striking out the period at the end of clause (8) and inserting in lieu thereof a comma and "and", and by inserting after clause (8) the following new clause:

"(9) in the case of a project for acquisition of a facility, reasonable assurance that the estimated total cost of acquisition of the facility and of any expansion, remodeling, and alteration of the acquired facility will not be greater than the estimated cost of construction of an equivalent new facility.";

(F) by inserting "(or of the estimated cost of facility acquisition and construction)" in clause (2) of subsection (b) after "cost of construction";

(G) by striking out "the construction of" in clause (4) of subsection (b) and inserting in lieu thereof "the carrying out of"; and

(H) in subsection (d)(1)—

(i) by inserting "(or of the estimated cost of facility acquisition and construction)" in the first sentence after "cost of construction";

(ii) by striking out "constructed" in the second sentence and inserting in lieu thereof "carried out";

(iii) by striking out "construction" in the third sentence and inserting in lieu thereof "the project"; and

(iv) by striking out "the construction of" in the fourth sentence.

38 USC 5036.

(4) Section 5036 is amended—

(A) by striking out "for construction" after "completion of any project";

(B) by inserting "acquisition," after "in the case of the";

(C) by striking out "value of such construction" and inserting in lieu thereof "value of such project";

(D) by striking out "for such construction" after "assistance provided for"; and

(E) by striking out "twenty" both places it appears and inserting in lieu thereof "20".

38 USC 5037.

(5) Section 5037 is amended by inserting "or acquired" after "constructed".

COORDINATION OF VETERANS' ADMINISTRATION HEALTH-CARE SERVICES WITH STATE AND LOCAL PROGRAMS

38 USC 220.

SEC. 106. (a) Section 220 is amended—

(1) by inserting "(a)" before "The Administrator"; and

(2) by adding at the end the following new subsection:

"(b) The Administrator shall seek to achieve the effective coordination of the provision, under laws administered by the Veterans' Administration, of benefits and services (and information about such benefits and services) with appropriate programs (and information about such programs) conducted by State and local governmental agencies and by private entities at the State and local level. In carrying out this subsection, the Administrator shall place special emphasis on veterans who are sixty-five years of age or older.".

(b)(1) The heading of such section is amended to read as follows:

"§ 220. Coordination and promotion of other programs affecting veterans and their dependents".

(2) The item relating to such section in the table of sections at the beginning of chapter 3 is amended to read as follows:

"220. Coordination and promotion of other programs affecting veterans and their dependents.".

MEDICAL AND REHABILITATIVE DEVICES

38 USC 617.

SEC. 107. Section 617 is amended—

(1) by inserting "(a)" before "The Administrator"; and

(2) by adding at the end the following new subsection:

"(b) The Administrator may furnish devices for assisting in overcoming the handicap of deafness (including telecaptioning television decoders) to any veteran who is profoundly deaf and is entitled to compensation on account of hearing impairment.".

AUTHORITY TO ADJUST RATES OF PAY FOR CERTAIN PSYCHOLOGISTS

97 Stat. 1000.
38 USC 4104.

SEC. 108. Section 4104 is amended—

(1) by inserting "(other than those described in paragraph (3))" after "psychologists" in paragraph (2); and

(2) by striking out "Certified" in paragraph (3) and inserting in lieu thereof "Clinical or counseling psychologists who hold

diplomas as diplomates in psychology from an accrediting authority approved by the Administrator, certified".

WAIVER OF MANDATORY REDUCTIONS IN MILITARY RETIRED PAY FOR CERTAIN PHYSICIANS

38 USC 4107.

SEC. 109. Section 4107 is amended by adding at the end the following new subsection:

"(i) The Administrator may authorize an exception to the restrictions in subsections (a), (b), and (c) of section 5532 of title 5 if necessary to meet special or emergency employment needs which result from a severe shortage of well-qualified candidates in physician positions which otherwise cannot be readily met.".

POST-TRAUMATIC-STRESS DISORDER

38 USC 612A note.

SEC. 110. (a)(1) The Chief Medical Director of the Veterans' Administration may designate special programs within the Department of Medicine and Surgery for the diagnosis and treatment of post-traumatic-stress disorder (hereinafter in this section referred to as "PTSD").

(2) The Chief Medical Director shall direct (A) that (in addition to providing diagnostic and treatment services for PTSD) Veterans' Administration programs designated under paragraph (1) (hereinafter in this section referred to as "designated PTSD programs") carry out activities to promote the education and training of health-care personnel (including health-care personnel not working for the Veterans' Administration or the Federal Government) in the causes, diagnosis, and treatment of PTSD, and (B) that (when appropriate) the provision of treatment services under such program be coordinated with the provision of readjustment counseling services under section 612A of title 38, United States Code.

Special Committee on Post-Traumatic-Stress Disorder, establishment.

(b)(1) The Chief Medical Director shall establish in the Department of Medicine and Surgery a Special Committee on Post-Traumatic-Stress Disorder (hereinafter in this section referred to as the "Special Committee"). The Chief Medical Director shall appoint qualified employees of the Department to serve on the Special Committee.

(2) The Special Committee shall assess, and carry out a continuing assessment of, the capacity of the Veterans' Administration to provide diagnostic and treatment services for PTSD to veterans eligible for health care furnished by the Veterans' Administration.

(3) The Special Committee shall also advise the Chief Medical Director regarding the development of policies, the provision of guidance, and the coordination of services for the diagnosis and treatment of PTSD (A) in designated PTSD programs, (B) in inpatient psychiatric programs and outpatient mental health programs other than designated PTSD programs, and (C) in readjustment counseling programs of the Veterans' Administration.

(4) The Special Committee shall also make recommendations to the Chief Medical Director for guidance with respect to PTSD regarding—

(A) appropriate diagnostic and treatment methods;

(B) referral for and coordination of followup care;

(C) the evaluation of PTSD treatment programs;

(D) the conduct of research concerning such diagnosis and treatment (taking into account the provisions of subsection (c));

(E) special programs of education and training for employees of the Department of Medicine and Surgery and the Department of Veterans' Benefits (also taking into account such provisions);

(F) the appropriate allocation of resources for all such activities; and

(G) any specific steps that should be taken to improve such diagnosis and treatment and to correct any deficiencies in the operations of designated PTSD programs.

National Center on Post-Traumatic-Stress Disorder, establishment.

(c) The Chief Medical Director shall establish and operate in the Department of Medicine and Surgery a National Center on Post-Traumatic-Stress Disorder. The National Center (1) shall carry out and promote the training of health care and related personnel in, and research into, the causes and diagnosis of PTSD and the treatment of veterans for PTSD, and (2) shall serve as a resource center for, and promote and seek to coordinate the exchange of information regarding, all research and training activities carried out by the Veterans' Administration, and by other Federal and non-Federal entities, with respect to PTSD.

(d) The Chief Medical Director shall regularly compile and publish the results of research that has been conducted relating to PTSD.

Report.

(e)(1) Not later than March 1, 1985, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the implementation of this section. The report shall include the following:

(A) A list of the members of the Special Committee.

(B) A list of all designated PTSD programs and other programs providing treatment for PTSD, together with a description of the resources that have been allocated for the development and operation of each such program, a description of the education and training that has been provided for Veterans' Administration health-care personnel in such programs and elsewhere within the Veterans' Administration in the diagnosis and treatment of PTSD, and specification of the funding that has been allocated to each such program and elsewhere within the Veterans' Administration to support research relating to PTSD.

(C) The assessment of the Chief Medical Director of the Veterans' Administration, after consultation with the Special Committee, regarding the capability of the Veterans' Administration to meet the needs for inpatient and outpatient PTSD diagnosis and treatment (both through designated PTSD programs and otherwise) of veterans who served in the Republic of Vietnam during the Vietnam era, former prisoners of war, and other veterans eligible for health care from the Veterans' Administration and the efficacy of the treatment so provided, as well as a description of the results of any evaluations that have been made of PTSD treatment programs.

(D) The plans of the Special Committee for further assessments of the capability of the Veterans' Administration to diagnose and treat veterans with PTSD.

(E) The recommendations made by the Special Committee to the Chief Medical Director and the views of the Chief Medical Director on such recommendations.

(F) A summary of the results of research conducted by the Veterans' Administration relating to PTSD.

(G) A description of the steps taken, plans made (and a timetable for their execution), and resources to be applied to implement subsections (b) and (c).

(H) The assessment of the Administrator of the capacity of the Veterans' Administration to meet in all geographic areas of the United States the needs described in subparagraph (C) and any plans and timetable for increasing that capacity (including the costs of such action).

(2) Not later than February 1, 1986, and February 1 of each of the three following years, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report containing information updating the reports submitted under this subsection before the submission of such report.

Report.

ALCOHOL AND DRUG TREATMENT AND REHABILITATION GUIDELINES

SEC. 111. Not later than six months after the date of the enactment of this Act, the Administrator of Veterans' Affairs (1) shall issue guidelines for the treatment and rehabilitation of veterans for alcohol or drug dependence or abuse disabilities under chapter 17 of title 38, United States Code, in facilities over which the Administrator has direct jurisdiction, and (2) shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report (including a copy of such guidelines) on the implementation of this section.

Report.

38 USC 601 *et seq.*

TITLE II—REPORTS

REPORT ON VETERANS' ADMINISTRATION PROGRAMS FOR TERMINALLY ILL VETERANS

SEC. 201. (a) Not later than September 30, 1985, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on programs of the Veterans' Administration to furnish palliative care, supportive counseling, and other medical services to terminally ill veterans and, pursuant to section 601(6)(B) of title 38, United States Code, supportive counseling to members of such veterans' families.

(b) The report required by subsection (a) shall include the following:

(1) A review of Veterans' Administration policies and guidelines on the provision of care, counseling, and services described in subsection (a).

(2) A review of the care, counseling, and services furnished, including the treatment modalities used and services furnished by the Veterans' Administration.

(3) An analysis and a comparison of the care, counseling, and services furnished with respect to terminally ill veterans in hospice and other Veterans' Administration programs, including a comparison of the routine and ancillary services, of the duration of inpatient and outpatient treatment and hospital-based home care, and of the cost of care furnished in such programs.

(4) An explanation of how the care, counseling, and services described in subsection (a) are or will be included in the overall plans of the Veterans' Administration for providing health care to older veterans in the future and the extent to which plans to furnish hospice care are included in such plans.

(5) A review of any steps taken to arrange for the exchange of information between Veterans' Administration facilities providing the care, counseling, and services described in subsection (a) and non-Veterans' Administration facilities providing similar care, counseling, and services.

VETERANS RESIDING IN REMOTE GEOGRAPHIC AREAS

Sec. 202. (a) The Congress makes the following findings:

(1) Many veterans with service-connected disabilities and other veterans eligible for certain health-care services from the Veterans' Administration, within the limits of Veterans' Administration facilities, reside in areas of the United States that are geographically remote from health-care facilities over which the Administrator of Veterans' Affairs has direct jurisdiction.

(2) For many such veterans such health-care facilities are geographically inaccessible and for many other such veterans the inconvenience of travel to such facilities discourages them from seeking health-care services from the Veterans' Administration.

(3) A study conducted by the Administrator of eligible veterans residing in remote areas and the use by those veterans of Veterans' Administration health-care services would provide useful information on the feasibility and appropriateness of alternative approaches to furnishing health-care services to such veterans.

Study.

(b)(1) The Administrator shall carry out a study to develop information about veterans who reside in remote areas and are eligible for health-care services from the Veterans' Administration and to develop alternative approaches that could be adopted to furnish such veterans with such services. In carrying out the study, the Administrator shall develop the following information:

(A) To the maximum extent feasible, statistics on the number of eligible veterans who, during fiscal year 1985—

(i) reside less than fifty miles from the nearest Veterans' Administration medical facility,

(ii) reside between fifty miles and one hundred miles from the nearest Veterans' Administration medical facility,

(iii) reside between one hundred miles and two hundred miles from the nearest Veterans' Administration medical facility, and

(iv) reside more than two hundred miles from the nearest Veterans' Administration medical facility.

(B) Statistics, shown by each group of veterans described in clause (A), on the numbers of eligible veterans who, during fiscal year 1985—

(i) use Veterans' Administration medical facilities,

(ii) receive inpatient care in such facilities (including the typical lengths of stay of such veterans in such facilities),

(iii) receive outpatient care from such facilities, and

(iv) receive followup health-care services from such facilities.

(C) Such additional statistics and such additional information as the Administrator considers appropriate.

(D) Breakdowns of the statistics described in clauses (A) and (B) with respect to age, service connection, and financial need regarding the applicable veteran populations.

(2) Not later than January 1, 1986, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a full report on the study under paragraph (1). The report shall include—

Reports.

(A) the statistics and breakdown developed and information gathered under that paragraph;

(B) the Administrator's findings on the extent of the need for the Veterans' Administration to increase health-care services in remote areas; and

(C) the Administrator's findings and recommendations regarding the advantages and disadvantages of the Veterans' Administration contracting for and making other arrangements for the furnishing of health-care services to eligible veterans in remote areas.

(3) Not later than July 1, 1986, the Administrator shall submit to such committees a report describing an experimental program that could feasibly be carried out through projects in five remote areas, selected on the basis of the information and findings included in the report under paragraph (2), to demonstrate alternative approaches for the Veterans' Administration to furnish health-care services to eligible veterans in remote areas. The report shall include a description of the health-care services, and a detailed breakdown of the costs for them, that could be furnished under such an experimental program to such veterans in each such area, along with the recommendations (and the reasons therefor) of the Administrator regarding whether any such project should be carried out and such recommendations for legislative or administrative action as the Administrator considers appropriate in light of the information contained in the report.

TITLE III—MISCELLANEOUS

MODIFICATION OF REVERSIONARY INTEREST IN CERTAIN LAND, LOS ANGELES, CALIFORNIA

Real property.

SEC. 301. (a) The Administrator of Veterans' Affairs shall execute such legal documents as are necessary to permit the use of the real property described in subsection (b) (or any portion of such property) for educational or cultural purposes in addition to the use of such property as a research and medical center and for allied purposes. The Administrator may carry out the preceding sentence subject to such terms and conditions as the Administrator requires in order to protect the interests of the United States.

(b) The real property referred to in subsection (a) is the property transferred to the State of California for the use of the University of California by a quitclaim deed dated December 10, 1948, executed by the Administrator of Veterans' Affairs under the Act entitled "An Act to authorize the Administrator of Veterans' Affairs to transfer a portion of the Veterans' Administration center at Los Angeles, California, to the State of California for the use of the University of California", approved June 19, 1948 (62 Stat. 559), and recorded in the land records of the County of Los Angeles, California, at page 307 of book 29032.

(c) Any document executed to carry out subsection (a) of this section shall provide that the property involved shall revert to the United States if it ceases to be used as a research and medical center or for educational or cultural purposes.

NAMING OF VETERANS' ADMINISTRATION MEDICAL CENTERS

SEC. 302. (a) The Veterans' Administration Medical Center in Murfreesboro, Tennessee, shall after the date of the enactment of this Act be known and designated as the "Alvin C. York Veterans' Administration Medical Center". Any reference to such medical center in any law, regulation, map, document, record, or other paper of the United States shall after such date be deemed to be a reference to the Alvin C. York Veterans' Administration Medical Center.

(b) The Veterans' Administration Medical Center in Milwaukee, Wisconsin, shall after the date of the enactment of this Act be known and designated as the "Clement J. Zablocki Veterans' Administration Medical Center". Any reference to such medical center in any law, regulation, map, document, record, or other paper of the United States shall after such date be deemed to be a reference to the Clement J. Zablocki Veterans' Administration Medical Center.

Approved October 19, 1984.

LEGISLATIVE HISTORY—H.R. 5618 (S. 2514):

HOUSE REPORT No. 98-779 (Comm. on Veterans' Affairs).
CONGRESSIONAL RECORD, Vol. 130 (1984):
    May 21, considered and passed House.
    Aug. 9, considered and passed Senate, amended, in lieu of S. 2514.
    Oct. 2, House concurred in Senate amendments with amendments.
    Oct. 3, Senate concurred in House amendments.
WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 20, No. 42 (1984): Oct. 19, Presidential statement.

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